



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 10, 2026

Licensee

Stanton House With Services Incorporated
3350 James Avenue North
Minneapolis, MN 55412

RE: Project Number(s) SL36467015

Dear Licensee:

On August 19, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on September 6, 2024. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-800-337-9238

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 6, 2025

Licensee
Stanton House W Services Inc.
3350 James Avenue North
Minneapolis, MN 55412

RE: Project Number(s) SL36467015

Dear Licensee:

On December 17, 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 on September 6, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 6, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 6, 2024, found not corrected at the time of the December 17, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00
0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)
0830 - Local Laws Apply - 144g.45 Subd. 3 - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 17, 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.

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

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

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.

We urge you to review these orders carefully. If you have questions, please contact at .

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,



Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2024
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 JAMES AVENUE N MINNEAPOLIS, MN 55412		
(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL#36467015-1 On December 17, 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 September 4, 2024. At the time of the survey, there were 0 residents: 0 receiving services under the Assisted Living License. As a result of the follow-up survey, the following orders were reissued.	{0 000}			
{0 250} SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or staff of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this	{0 250}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 250}	Continued From page 1 chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or staff; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by:	{0 250}			

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{0 330} SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by:	{0 330}			
{0 460} SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;	{0 460}			

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{0 460}	Continued From page 3 This MN Requirement is not met as evidenced by:	{0 460}			
{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 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:	{0 470}			

Minnesota Department of Health

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{0 480}	Continued From page 4	{0 480}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;	{0 480}			

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{0 480}	Continued From page 5 (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}			
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of	{0 550}			

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{0 550}	Continued From page 6 Health. This MN Requirement is not met as evidenced by:	{0 550}			
{0 570} SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by:	{0 570}			
{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. This MN Requirement is not met as evidenced by:	{0 580}			

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{0 630}	Continued From page 7	{0 630}			
{0 630} SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by:	{0 630}			
{0 640} SS=C	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:	{0 640}			

Minnesota Department of Health

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{0 640}	Continued From page 8	{0 640}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, 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:	{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	{0 660}			

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{0 660}	Continued From page 9 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. This MN Requirement is not met as evidenced by:	{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	{0 680}			

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{0 680}	Continued From page 10 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:	{0 680}			
{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:	{0 700}			
{0 730} SS=F	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	{0 730}			

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{0 730}	Continued From page 11 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 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:	{0 730}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 JAMES AVENUE N MINNEAPOLIS, MN 55412		
(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
{0 730}	Continued From page 12	{0 730}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents.	{0 780}			

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{0 780}	Continued From page 13 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 December 17, 2024, at 1:15 p.m. on a follow up visit, survey staff toured the facility with owner. Owner tested the smoke alarms in the upstairs and mainfloor bedrooms and in the immediate area right outside the bedrooms. These alarms were verified as working and interconnected with one another. The basement bedroom was newly remodled and had wiring hanging from the ceiling where the new smoke alarm will go but had not been installed yet. A smoke alarm is required in the basement bedroom and one right outside the basement bedroom. These deficient conditions were visually verified by owner accompanying on the tour. Owner stated they understood the smoke alarm requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	{0 780}			
{0 820} SS=E	144G.45 Subd. 2 (g) Fire protection and physical environment	{0 820}			

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{0 820}	Continued From page 14 (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 provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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 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 December 17, 2024, at 1:30 p.m., survey staff toured the facility with owner. During the tour, survey staff explained to the owner the noncompliant measurements.	{0 820}			

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{0 820}	Continued From page 15 UNOCCUPIED SLEEPING ROOMS: Bedroom on main floor to the left of the hallway: Window measured 30 inches clear width, 21.5 inches clear height, and 645 square inches total open area. Bedroom on main floor to the right of the hallway: Window measured 24 inches clear width, 21.5 inches clear height, and 516 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to owner that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 820}			
{0 830} SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.	{0 830}			

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{0 830}	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 17, 2024, at 1:30 p.m., on a follow up survey, survey staff toured the facility with owner. At the time of the survey, the basement was still under construction. The new bathroom and bedroom was missing trim, flooring, lights, plug ins outlets and smoke alarms. Owner said the contractor was still in the process of installing these items. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	{0 830}			
{0 900} SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written	{0 900}			

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{0 900}	Continued From page 17 contract with the resident. (b) The contract must contain all the terms concerning the provision of: (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:	{0 900}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or	{0 970}			

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{0 970}	Continued From page 18 should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	{0 970}			
{0 980} SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by:	{0 980}			
{01290} SS=F	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	{01290}			

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{01290}	Continued From page 19 section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by:	{01290}			
{01460} SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors (a) All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility, except as provided in paragraph (b). (b) A staff person is not required to repeat the orientation required under subdivision 2 if the staff person transfers from one licensed assisted living facility to another facility operated by the same licensee or by a licensee affiliated with the same corporate organization as the licensee of the first facility, or to another facility managed by the same entity managing the first facility. The facility to which the staff person transfers must document that the staff person completed the orientation at the prior facility. The facility to which the staff person transfers must nonetheless provide the transferred staff person with supplemental orientation specific to the facility	{01460}			

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{01460}	Continued From page 20 and document that the supplemental orientation was provided. The supplemental orientation must include the types of assisted living services the staff person will be providing, the facility's category of licensure, and the facility's emergency procedures. A staff person cannot transfer to an assisted living facility with dementia care without satisfying the additional training requirements under section 144G.83. This MN Requirement is not met as evidenced by:	{01460}			
{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 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	{01470}			

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{01470}	Continued From page 21 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 staff member 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:	{01470}			

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{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 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	{01500}			

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{01500}	Continued From page 23 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:	{01500}			
{01530} SS=D	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	{01530}			

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{01530}	Continued From page 24 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:	{01530}			
{01560} SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by:	{01560}			

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{01560}	Continued From page 25	{01560}			
{01610} SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by:	{01610}			
{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	{01620}			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/17/2024
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 JAMES AVENUE N MINNEAPOLIS, MN 55412		
(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
{01620}	Continued From page 26 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 by:	{01620}			
{01630} SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by:	{01630}			
{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	{01640}			

Minnesota Department of Health

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{01640}	Continued From page 27 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:	{01640}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	{01650}			

Minnesota Department of Health

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{01650}	Continued From page 28 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by:	{01650}			
{02430} SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by:	{02430}			

Minnesota Department of Health

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{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:	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

September 25, 2024

Licensee

Stanton House With Services Incorporated
3350 James Avenue North
Minneapolis, MN 55412

RE: Conditional License Number 417176
Health Facility Identification Number (HFID) 36467
Project Number(s) SL36467015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 6, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the 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 **December 24, 2024**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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.

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 \$500.00. **MDH is not imposing these fines against your license at this time.**

St - 0 - 0330 - 144g.30 Subd. 4 - Information Provided By Facility - \$500.00

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 and immediately correct any reissued orders 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.**

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.

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 Stanton House With Services Incorporated 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 Stanton House With Services Incorporated is in substantial compliance.

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

- a. **No new admissions:** Stanton House With Services Incorporated will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Stanton House With Services Incorporated must provide the Department:

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

- b. Fix Hazards:** Stanton House With Services Incorporated must complete construction in the building in accordance with the building official, fire official and MDH to bring the building into compliance with the requirements of Minnesota Statutes Chapter 144G. The following items apply for review and approval by MDH Engineering:
- i. Any work performed by you or your contractor that takes place, must be documented on plans signed by a licensed architect/engineer to show compliance with Facility Guidelines Institute Standards and National Fire Protection Association Standard 101.
 - 1. If you have any different occupancies or entities operating out of this building, please ensure there is at least a 2-hour fire barrier that separates the building, they have separate entrances from the assisted living facility, and separate addresses; and
 - 2. Submit the engineer/architect signed plans in accordance with our plan submittal process as defined on our website:
 - i. <https://www.health.state.mn.us/facilities/regulation/engineering/assistedliving.html>.
 - ii. Provide MDH with a copy of the building permit issued by the City of Minneapolis.
 - iii. Those plan submittals must be reviewed and approved by MDH prior to construction.
 - iv. When construction is complete, schedule an inspection with the MDH engineer that reviewed the plans. All work must be complete and compliant with the requirements of Minnesota Statutes Chapter 144G for conditions to be lifted.

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

MDH will determine if Stanton House With Services Incorporated 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 Stanton House With Services Incorporated is in substantial compliance on the follow up survey, MDH will remove the conditions from Stanton House With Services Incorporated's assisted living facility license, and Stanton House With Services Incorporated will correct any outstanding violations identified during the survey. If Stanton House With Services Incorporated 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 Tim Hanna directly at: 507-208-8982.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

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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: SL36467015 On September 3, 2024, through September 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were zero residents receiving services under the Assisted Living license.	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.		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter;	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations; and responsible for the resident's assisted living services, understood all of the assisted living facility regulations. This had the potential to affect all residents. 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: During the entrance conference on September 3, 2024, at 1:12 p.m. licensed assisted living director (LALD)-A stated she familiar with the assisted living regulations.	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 The licensee's "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified, "I certify I have read and understand the following:" [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45 (opens in a new window), my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17 (opens in a new window). - I have read and fully understand Minn. Stat. sect. 144G.80 (opens in a new window), 144G.81 (opens in a new window). and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22 (opens in a new window), my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G (opens in a new window). - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659 (proposed and not final) (opens in a new window). - Reporting of Maltreatment of Vulnerable Adults (opens in a new window). - Electronic Monitoring in Certain Facilities (opens in a new window)." - "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G (opens in a new window), and Minnesota Rules, chapter 4659 (proposed and not final) (opens in a new window), governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence f a management agreement or subcontract." - "I have examined this application and all	0 250			

Minnesota Department of Health

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0 250	Continued From page 4 attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." - I attest to have all required policies and procedures of Minn. Stat. chapter 144G (opens in new window). and Minn. Rules chapter 4659 (proposed and not final) (opens in new window), in place upon licensure and to keep them current as applicable." Page five was electronically signed by the LALD-A on May 22, 2024. The licensee had an assisted living license, effective April 18, 2024, with an expiration date of April 18, 2025. As a result of this survey, the following correction orders were issued 0330, 0460, 0470, 0480, 0550, 0570, 0580, 0630, 0640, 0650, 0660, 0680, 0700, 0730, 0780, 0790, 0800, 0810, 0820, 0830, 0900, 0970, 0980, 1290, 1460, 1470, 1500, 1530, 1560, 1610, 1620, 1630, 1640, 1650, 2430, and 3090 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250			

Minnesota Department of Health

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0 330	Continued From page 5	0 330			
0 330 SS=F	144G.30 Subd. 4 Information provided by facility (a) The assisted living facility shall provide accurate and truthful information to the department during a survey, investigation, or other licensing activities. (b) Upon request of a surveyor, assisted living facilities shall within a reasonable period of time provide a list of current and past residents and their legal representatives and designated representatives that includes addresses and telephone numbers and any other information requested about the services to residents. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide accurate and truthful information during a survey. 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: The licensee held an assisted living facility license effective April 18, 2024, with an expiration date of April 18, 2025. On September 3, 2024, at approximately 10:25 a.m., the Minnesota Department of Health (MDH) surveyor was outside at the licensee's facility (a residential-style home) to initiate a survey. There was a no soliciting sign adhered to a blackened	0 330			

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3350 JAMES AVENUE N MINNEAPOLIS, MN 55412		
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0 330	Continued From page 6 storm (front) door. On September 3, 2024, at approximately 10:30 a.m., licensed assisted living director (LALD)-A walked up to the surveyor, outside the facility, and stated she did not have access to the facility. LALD-A said she did not have a key. LALD-A added there were no current residents residing at the facility. On September 3, 2024, at 10:35 a.m., LALD-A said she had "people," "squatters" residing in the facility. LALD-A stated she was able to get them (squatters) out and hired someone to fix the facility up and he (contractor/carpenter) took the key. LALD-A added she did not need the key to the facility and told the contractor/carpenter he could keep the key. RESIDENT RECORDS On September 3, 2024, at 10:39 a.m., LALD-A stated she was not willing to hire a locksmith to gain access to the facility. LALD-A said records were inside the facility. On September 3, 2024, at 10:46 a.m., LALD-A stated she would continue to try to contact the person who had the key to gain access to the facility. On September 3, 2024, at 11:28 a.m., LALD-A noted in an email, "As I stated. We (licensee) have the records. All our records are kept in our office at 3354 James. The only issue we are having is accessing the house at 3350 James." On September 3, 2024, at 1:25 p.m., during the entrance conference LALD-A stated resident records included documentation that was both electronic and paper form. LALD-A said, "nothing	0 330			

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0 330	Continued From page 7 here" (resident records). LALD-A stated, the records were at the other place (another facility, with a different health identification/HFID). On September 4, 2024, at 3:26 p.m., LALD-A stated some of the records got destroyed at the facility. LALD-A said she had a locked cabinet at the facility, and "people" were in there (facility), and "they (people/squatters) could have thought something of value was in there (cabinet) and destroyed the cabinet and the records." RESIDENT(S) On September 3, 2024, at 8:45 a.m., the surveyor sent an email to the licensee and requested a current resident roster, and discharge or deceased resident roster. On September 3, 2024, at 1:41 p.m., the surveyor received a discharged or deceased resident roster for the licensee from LALD-A. The resident roster included three names handwritten on the form, the form was dated January 18, 2024, HFID 32730. [This facility HFID 36467]. R1-diagnosis, "N/A" (not applicable), discharged back home; was termination of services notice and AL (assisted living) contract termination notice provided? no. R2-diagnosis code G82.50 (paraplegia/paralysis of legs and lower body), discharged to: another facility; was termination of services notice and AL contract termination notice provided? yes R3-diagnosis code M15.0 (arthritis), discharged to: another facility: was termination of services notice and AL contract termination notice provided? yes. In addition, on the bottom of the roster were notes regarding discharge reasons for R2 and R3. On September 3, 2024, at approximately 3:15	0 330			

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0 330	Continued From page 8 p.m., LALD-A stated R1 received only housing services. On September 4, 2024, at 7:19 a.m., the surveyor requested, via email, R1's contract and abuse prevention plan as LALD-A stated R1 was only receiving housing services. LALD-A was informed a full record review would be completed on one of the other two residents (R2) listed on the resident roster received on September 3, 2024, at 1:41 p.m. On September 4, 2024, at 7:49 a.m., the surveyor received an email from LALD-A that noted," yes, it was only housing for (R1). And for R2 we have a full file on him (R2), but he (R2) did not live at 3350 [facility being surveyed]". On September 4, 2024, at 8:24 a.m., the surveyor received an email from LALD-A that noted, "(R1) would be our only resident in the past year. In a sense, he (R1) received services because he (R1) got 24-hour supervision and assistance with ADLs (activities of daily living); prompting, cueing, and making sure he (R1) bathed, and groomed. No hands-on assistance was needed, and he (R1) didn't take medications so we (licensee) didn't keep a MAR (medication administration record)". On September 4, 2024, at 10:35 a.m., the surveyor received a discharged or deceased resident roster dated January 18, 2024, HFID 36467. The roster included one name, R1-diagnosis, "N/A", discharged back home; was termination of services notice and AL (assisted living) contract termination notice provided? no. On September 4, 2024, at 2:06 p.m., LALD-A stated R1 did his own medications and his own	0 330			

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0 330	Continued From page 9 food. They (staff) came to check, they did not stay here. They (staff) should of, not sure if staff stayed at the facility. On September 4, 2024, at 2:08 p.m., LALD-A stated yes, staff stayed at the facility. On September 4, 2024, at 3:10 p.m., CNS-C stated a discharge summary was not done for R1. CNS-C said, "he (R1) just left." On September 4, 2024, at 3:11 p.m., LALD-A and CNS-C stated R1 received services. On September 4, 2024, at 3:12 p.m., the surveyor inquired if the ombudsman was notified of R1's departure, was it an emergency? CNS-C said she did not think notice was given (to ombudsman) when R1 left, adding she (CNS-C) would have to look for it. CNS-C stated a MAARC (mandated reporting of maltreatment of vulnerable adults) report was not completed. CNS-C said the licensee did not do much for R1: "gave him food, changed, go to the bathroom, take a bath." CNS-C stated," Someone (staff) checked on him (R1)." CNS-C said someone (staff) stayed with him (R1). On September 4, 2024, at 3:26 pm., CNS-C stated they (licensee) tried to make it look like R1 was not a resident. On September 5, 2024, at 11:42 a.m., LALD-A noted via email, "we (licensee) did not need to file a report when R1 moved. R1 moved back to his home. We (licensee) knew he was only staying about a month and that he would be returning home. R1 did not elope." STAFFING ROSTER	0 330			

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0 330	Continued From page 10 On September 3, 2024, at 8:45 a.m., the surveyor requested a facility staff roster from the licensee. On September 4, 2024, at approximately 10:00 a.m., LALD-A provided the surveyor a staffing roster that included five unlicensed personnel (ULP) names, dates of hire, and phone numbers. The surveyor immediately requested a complete staffing roster to include LALD-A, and CNS-C. On September 4, 2024, at 10:52 a.m., LALD-A provided the surveyor a staffing roster that included six ULPs names, dates of hire, and phone numbers (none were on the prior list). The roster included an agency lead, LALD-A, and CNC-C with dates of hire, and phone numbers. On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor the facility's "staffing plan" which consisted of five pages, titled with the licensee's name and address. Pages were dated December 5, 2023, through January 5, 2024. -ULP-B's name was listed on the schedule several times, to include December 9, 2023, through December 11, 2023, 7:00 p.m. until 7:00 a.m., and January 2, 2024, through January 5, 2024, 7:00 p.m. until 7:00 a.m. -ULP-D's name was listed on the schedule several times, to include December 9, 2023, through December 11, 2023, 7:00 a.m. until 7:00 p.m., and January 2, 2024, through January 5, 2024, 7:00 a.m. until 7:00 p.m. -ULP-E's name was listed on the schedule several times, to include December 5, 2023, through December 8, 2023, 7:00 a.m. until 7:00 p.m., and January 2, 2024, through January 5, 2024, 7:00 a.m. until 7:00 p.m., and December 30, 2023, through January 1, 2024. -ULP-F's name was listed on the schedule several times, to include December 5, 2023,	0 330			

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0 330	Continued From page 11 through December 8, 2023, 7:00 p.m., until 7:00 a.m. and December 30, 2023, through January 1, 2024, 7:00 p.m. until 7:00 a.m. On September 5, 2024, at 8:20 a.m., the surveyor requested the names, dates of birth, dates of hire, position, and phone numbers for ULP-B, ULP-D, ULP-E, ULP-F (not previously on staff rosters provided by LALD-A). On September 5, 2024, at 11:17 a.m., LALD-A emailed the surveyor an updated staff roster, dated December 4, 2023, four names were listed, ULP-B, ULP-D, ULP-E, ULP-F. STAFFING On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor an undated plan/schedule for the facility, 3350 James Ave North, which noted staff worked from 7:00 a.m. -7:00 p.m., and 7:00 p.m. -7:00 a.m. Four ULP names were on the staffing plan/schedule and included: -December 9, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 10, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 11, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 19, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 20, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 21, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 22, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 23, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 24, 2023, 7:00 a.m.-7:00 p.m., ULP-D -December 25, 2023, 7:00 a.m.-7:00 p.m., ULP-D -January 2, 2024, 7:00 a.m.-7:00 p.m., ULP-D -January 3, 2024, 7:00 a.m.-7:00 p.m., ULP-D -January 4, 2024, 7:00 a.m.-7:00 p.m., ULP-D -January 5, 2024, 7:00 a.m.-7:00 p.m., ULP-D. On September 5, 2024, from 1:39 p.m. until 5:40 p.m., the surveyor made several phone calls to the four ULP on the staffing plan/schedule. Two	0 330			

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0 330	Continued From page 12 of the phone numbers were no longer in use, one phone number indicated "user busy" on the screen (three attempts made). Two messages were left on one of the phone numbers provided. On September 5, 2024, at 5:40 p.m., ULP-D stated she worked for the licensee. ULP-D said she worked morning shifts, 11 or 12-hour shifts. ULP-D stated she "bathed people, fed them, took them to appointments." The surveyor explained to ULP-D that she was only interested in what occurred at one facility, 3350 North James Ave. ULP-D said, "I never was there, at a house, when there was just one resident, and I never worked with any (name/R1)." The surveyor was not able to contact the other three ULPs listed on the schedule provided, several attempts were made. Based on record review and interviews regarding information provided, the surveyor was unable to determine documentation supplied during the survey was accurate and truthful information, as interviews and documents provided conflicting information. The licensee's undated Resident Records policy noted a resident record would be maintained for every person receiving assisted living services. Resident records are legal documents containing comprehensive, accurate and organized information concerning the resident's health and emotional status, and treatments and services rendered by the nurses, therapists and other health care team members. The Minnesota Bill of Rights for Assisted Living dated November 8, 2021, noted residents have the right to receive health care and other assisted	0 330			

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0 330	Continued From page 13 living services with continuity from people would are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 330			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all any residents	0 460			

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0 460	Continued From page 14 residing at the facility. In addition, the licensee failed to ensure resident's had a lockable door to the resident's unit. 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: The licensee held an assisted living facility license and was licensed for a capacity of five residents, with a census of zero residents residing in the facility. ASSISTANCE REQUEST During the entrance conference on September 3, 2024, at 1:15 p.m., licensed assisted living director (LALD)-A stated the licensee used a call pendant type of system for residents to request assistance at the facility. On September 3, 2024, at 3:17 p.m., during a facility tour with LALD-A, the surveyor did not observe a call system in resident rooms or in the facility for residents to summons staff. LOCKABLE DOOR On September 3, 2024, at approximately 3:25 p.m., during the tour of the facility LALD-A stated, "this room" (appeared to once have been a family room, generous size of opening) would be divided and two residents would share the space. The room did not have a door; however, the room had a fireplace, a large picture window with side	0 460			

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0 460	Continued From page 15 lights, and an exit door. On September 4, 2024, at 11:14 a.m., LALD-A stated the facility did not currently have a call system set up and a call system had not been in place for "six months". In addition, LALD-A stated she could put a door up and have it lockable. LALD-A confirmed there was not a lockable door present at the current time for a room intended for two residents' occupancy. R1's Assisted Living contract signed by LALD-A on December 2, 2023, and had "guardian signed" on resident signature line noted all residents are provided with a 24-hour emergency call system and all resident rooms have security locks. The Minnesota Bill of Rights for Assisted Living dated November 8, 2021, noted residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resdient's unit. Only a staff member with a specific need to enter the unit shall have keys. No other information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
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 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	0 470			

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0 470	Continued From page 16 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 interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of all residents; and failed to ensure the staffing schedule was posted as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 470			

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0 470	Continued From page 17 The findings include: The licensee held an assisted living license. The facility was licensed for a capacity of five and had a current census of zero residents. On September 3, 2024, at approximately 1:30 p.m., during the entrance conference, licensed assisted living director (LALD)-A stated the licensee developed and implement a staffing pan that was evaluated twice a year. On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor the facility's "staffing plan" which consisted of five pages, titled with the licensee's name and address. The pages were dated: -December 5, 2023, through December 8, 2023 -December 9, 2023, through December 15, 2023 -December 16, 2023, thorough December 22, 2023 -December 23, 2023, through, December 29, 2023 -December 30, 2023, through January 5, 2024. The pages noted the names of four unlicensed personnel (ULP) and shifts: 7:00 a.m., -7:00 p.m., and 7:00 p.m., -7:00 a.m. The following was printed on the bottom of each page: PIC (person in charge?): the PIC of the day will always be the aide who is assigned to all rooms. On call aide assistance available as needed. Please call (phone number) to request assistance! (Repeated). There must be a three-hour advanced notice when calling in!! Failure to do so will result in disciplinary action. On September 4, 2024, at 12:30 p.m., the five pages of the licensee's staffing plan were reviewed with LALD-A. LALD-A said she did not have a staffing plan for this facility. LALD-A	0 470			

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0 470	Continued From page 18 asked, so do I do that (staffing plan) for this house? On September 4, 2024, at 3:43 p.m., clinical nurse supervisor (CNS)-C stated a staffing plan had not been completed, adding she was not aware of the requirement. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4, effective October 2022, the daily work schedule in item A must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0180, Subp. 4., effective October 2022, the CNS must develop a 24-hour daily staffing schedule. The schedule must: (1) include direct-care staff work schedules for each direct-care staff member showing all shifts, including days and hours worked; and (2) identify the direct-care staff member's resident assignments or work location. 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 19 (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 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 September 4, 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			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities	0 550			

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0 550	Continued From page 20 and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the grievance procedure. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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 3, 2024, at 1:34 p.m., during the entrance conference licensed assisted living director (LALD)-A stated the licensee had a complaint procedure in place. On September 3, 2024, at 3:17 p.m. during a tour of the facility with LALD-A, the surveyor did not observe a grievance procedure posting to include the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to Minnesota	0 550			

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0 550	Continued From page 21 Adult Abuse Reporting Center (MAARC) in the common's area of the facility. LALD-A said she did not have required information posted at the current time. LALD-A stated she would have a "board" and post the required information on the board. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview,Not the licensee failed to display the original current license at the main entrance of the assisted living facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On September 3, 2024, at 1:00 p.m., upon entering the facility, the surveyor did not observe	0 570			

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0 570	Continued From page 22 the license posted at the facility main entrance, as required. On September 3, 2024, at 3:17 p.m., during a tour of the facility with licensed assisted living (LALD)-A, she stated had none of the required information posted because, "I (LALD-A) don't have anyone (residents) here." LALD-A confirmed the facility lacked the required posting. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0040, Subp. 2, effective October 2022, the facility must post the original license certificate issued by the commissioner at the main public entrance of the facility. A campus with multiple buildings must post the original certificate issued by the commissioner at the main public entrance of each building licensed as a facility on the campus. A separate license certificate shall be issued for each building on the campus. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21)	0 570			
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	0 580			

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0 580	Continued From page 23 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 September 3, 2024, at 1:35 p.m., during the entrance conference licensed assisted living director (LALD)-A stated the licensee did quality management meetings and she (LALD-A) could call to find out what the current focus/topic was. On September 4, 2024, at 11:47 a.m., LALD-A gave the surveyor "meeting notes" dated January 8, 2024, February 26, 2024, March 5, 2024, April 1, 2024, May 6, 2024, June 3, 2024, July 1, 2024, August 4, 2024. Each month had a list of topics that varied, such as: communication, residents/ shift notes, showering residents, cleaning duties, schedules, "know what days you work. Shift changing, time off," nurses-teaching, medication, activities with	0 580			

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0 580	Continued From page 24 residents, COVID tests, when to call nurse, and entries with names and/or initials about residents (cares, insulin monitoring, smells), etc. On September 4, 2024, at 11:59 a.m., LALD-A stated all the "houses" (facilities/three) meetings were done together. The licensee's policy was reviewed with LALD-A who confirmed the policy was not being followed for quality management and added the meetings would be done differently in the future. The licensee's undated Quality Management Program policy noted, this facility shall develop a continuous quality management program to identify, support and maintain the facility's quality improvement efforts and provide quality service to the resident. All staff would be involved in the implementation of performance improvement activities. Outcome measurement of these activities would be monitored on a continues basis and all results would be reported, at least annually, to the management team. The Quality Management Program would identify and address resident service areas that are high volume, high risk, or problem prone. Methods of organizational review and data collection would include, but was not limited to: -clinical record review -resident satisfaction surveys -incident reports -medication errors -falls with injury resident complaints -evaluation of clinical competence- infection control. Quality management data and information that would be evaluated by the quality Team would include: -complaint investigations and resolutions -vulnerable adult reports to the Common Entry Point	0 580			

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0 580	Continued From page 25 -audits of resident records -audits of employee records -survey results of MDH (Minnesota department of Heath) surveys -falls with injury -medication management issues. Outcome measurement of these activities would be monitored on a continuous basis and all results would be reported, at least annually, to the management team. Retention of reports and finding of the Quality Team would be retained in the facility files for two years. Documents would include a summary of meetings, projects and data collection, and findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the	0 630			

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0 630	Continued From page 26 licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of one discharged 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 of the residents). The findings include: R1's record noted R1's diagnosis as multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues.) On September 6, 2024, at 9:52 a.m., R1's guardian stated R1 had dementia, short term, from a stroke, and MS. In addition, R1's guardian stated R1 had been falling, and R1 was paranoid and would not take medication or eat some foods, adding, R1 thought something was put into R1's food. R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. R1's Individual Abuse Prevention Assessment	0 630			

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0 630	Continued From page 27 and Plan, dated December 2, 2023, included: -mobility: no known concerns -eating/drinking; no known concerns -toileting: no known concerns -personal hygiene/grooming, needs some supervision/assistance, prompting/cueing -dressing: no known concerns -health care: no known concerns -speech/communication: no known concerns -financial: no known concerns -human sexuality: no known concerns -self-preservation: no known concerns -behavioral: no known concerns -community orientation: no known concerns. R1's record did not include an individual abuse prevention plan which assessed the resident's susceptibility to abuse by another individual, including other vulnerable adults; R1's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to the resident and other vulnerable adults. On September 4, 2024, at 11:30 a.m., the surveyor reviewed R1's abuse prevention plan with licensed assisted living director (LALD)-A. LALD-A stated she did not "see" (find) on the R1's assessment the risk of R1's being abused by others, including other vulnerable adults on the assessment. LALD-A confirmed R1's assessment did not contain required information. The licensee's undated Abuse Prevention Plan noted all residents admitted to the facility would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The facility would develop a statement of the specific measure that would be taken to minimize	0 630			

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0 630	Continued From page 28 the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan would be incorporated into the resident care plan and would reflect their ability to participate in and direct their own care in the presence of an identified caregiver. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 640 SS=C	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 post the required content in common areas, including posting the 911 emergency number and contact information for Minnesota Adult Abuse Reporting Center (MAARC) in common areas on the main floor of the facility. This had the potential to affect residents, staff and visitors.	0 640			

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0 640	Continued From page 29 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: On September 3, 2024, at 1:00 p.m., upon entering the facility, the surveyor did not observe the required postings of 911 emergency number or MAARC contact information on the main level of the facility. On September 3, 2024, at 3:17 p.m., during a tour of the facility licensed assisted living director (LALD)-A stated she did not have any of the required information posted "because, I (LALD-A) don't have anyone (residents) here." LALD-A confirmed the facility lacked required postings. LALD-A said she would put up a board with the required posting, adding she would have put one up if she knew we (MDH/Minnesota Department of Health) were coming. The licensee's undated Emergency Procedure/911 Calls policy noted, the policy is appropriate for facilities providing services to residents living in a Housing-with Services Assisted Living Establishment. Appropriate modifications should be made for residents living in other settings. "Our facility and all staff respond promptly and appropriately to resident emergencies." No further information was provided.	0 640			

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0 640	Continued From page 30	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 for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel /ULP-B).	0 650			

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0 650	Continued From page 31 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: CNS-C CNS-C was hired on February 20, 2020, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On September 3, 2024, at 1:13 p.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility. CNS-C's employee record contained: -RN license, expiration date May 31, 2024 -background studies for health facility identification (HFID) 32730, and HFID 25977. CNS-C's employee record did not include all required documentation to include: -job description -evidence of current professional licensure -documentation of the background study as required under section 144.057 for HFID 36467 -documentation of annual performance reviews that identify areas of improvement needed and training needs. On September 3, 2024, at 2:19 p.m., LALD-A stated she "sees" CNS-C's RN license in CNS-C's employee record was expired.	0 650			

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0 650	Continued From page 32 On September 3, 2024, at 2:23 p.m., LALD-A stated "why does a nurse need a performance review, or annual training? She (CNS)-C is a nurse." LALD-A confirmed CNS-C record lacked a performance review. On September 4, 2024, at 2:02 p.m., LALD-A handed the surveyor evidence of current professional licensure for CNS-C, and a background study for the correct HFID number for CNS-C. ULP-B ULP-B was hired on August 9, 2022, to provide direct care services to the licensee's residents. On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor the facility's "staffing plan" which consisted of five pages, titled with the licensee's name and address. ULP-B's name was listed on the schedule several times, to include December 9, 2023, through December 11, 2023, from 7:00 p.m. until 7:00 a.m., and. January 2, 2024, through January 5, 2024, from 7:00 p.m. until 7:00 a.m. JOB DESCRIPTION ULP-B's employee record included a job description dated August 15, 2022. ULP-B's job description did not identify the person providing supervision as required. On September 6, 2024, at 9:31 a.m., LALD-A reviewed ULP-B's job description with the surveyor, and stated, "ok, no it does not say who would provide supervision to ULP-B." LALD-A confirmed ULP-B's job description did not include required information.	0 650			

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0 650	Continued From page 33 TRAINING ULP-B's employee record included a training record with entries dated August 14, 2022, and August 15, 2022. The record included: -orientation to assisted living requirements. ULP-B's orientation to assisted living requirements did not include a date completed, name of instructor, and the form did not include ULP-B's signature. On September 6, 2024, at 9:21 a.m., LALD-A stated ULP-B received the orientation to assisted living as required. LALD-A said, "that little box" not being checked was an over site. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing	0 650			

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0 650	Continued From page 34 the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The licensee's undated Employee Records policy noted employee records must include the following information: -evidence of current professional licensure, registration, or certification if licensure, registration or certification is required -records of orientation, require annual training, infection control training and competency evaluations -current signed job descriptions, including qualifications, responsibilities and identification of staff persons providing supervision -documentation of annual performance reviews that identify areas of improvement needed and training needs -documentation of the background study as required under section 144.057. The licensee's undated Facility Employee Orientation policy noted completion of the orientation training shall be documented in the employee's personnel file. 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	0 660			

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0 660	Continued From page 35 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH) to include a tuberculin skin test (TST) or blood test to rule out TB for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-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) 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: The facility's TB risk assessment was completed on March 5, 2023, indicated low risk, and noted	0 660			

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0 660	Continued From page 36 the TB risk assessment would be updated every two years. CNS-C CNS-C was hired on February 20, 2020, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On September 3, 2024, at 1:13 p.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility. CNS-C's employee record included: -TB risk assessment dated February 22, 2022. CNS-C's employee record did not include a TST or QuantiFERON TB-Gold test (blood test) for TB. On September 4, 2024, at 2:02 p.m., LALD-A stated CNS-C did not have a TST or other TB test completed, adding CNS-C just went to have one done, "get a shot." LALD-A confirmed CNS-C's TB testing requirement had not been completed as required. On September 6, 2024, at 8:37 a.m., CNS-C stated she did not go to get a TB test on September 4, 2024. CNS-C said in the past she did have a QuantiFERON TB-Gold test completed however it was completed greater than 90 days from her hire date at this facility. ULP-B ULP-B was hired on August 9, 2022, to provide direct care services to the licensee's residents. On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor the facility's "staffing plan"	0 660			

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0 660	Continued From page 37 which consisted of five pages, titled with the licensee's name and address. ULP-B's name was listed on the schedule several times, including December 9, 2023, through December 11, 2023, from 7:00 p.m. until 7:00 a.m., and January 2, 2024, through January 5, 2024, from 7:00 p.m. until 7:00 a.m. ULP-B's employee record included: - TB risk assessment dated August 17, 2022. ULP-B's employee record did not include a TST or blood test for TB. On September 5, 2024, at approximately 2:15 p.m., ULP-B's employee record was reviewed with LALD-A. LALD-A confirmed ULP-B's employee record did not include a TB test and ULP-B's TB testing requirement had not been completed as required. The licensee's Tuberculosis Prevention and Control policy noted the facility would, at no cost to the employee, offer TB Mantoux skin test or a blood test at the time of employment, and as indicated in situation of TB exposure. Employees who can show evidence of a negative Mantoux within three months prior to hire date may use that test as step one of two step test at the tie of employment. Employees who have documentation of a negative blood test or a negative chest x-ray with three months of employment do not need to have it repeated. A two-step TST is required for baseline TB screening of health care workers who have not had a TB within the previous three months of hire. For all employees, volunteers or contract personnel providing direct resident care, there shall be evidence of baseline TB screening consisting of two components.	0 660			

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0 660	Continued From page 38 The MDH guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, screen (no symptoms of active TB disease) and a negative IGRA or TST (first step) dated within 90 days before hire. 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	0 680			

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0 680	Continued From page 39 requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed have a written emergency preparedness plan (EPP) posted in a prominent area and developed 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:40 p.m., licensed assisted living director (LALD)-A stated they don't currently have the board up, where the facility EPP would have been posted. LALD-A added, "I (LALD)-A don't think I ever had one here to be totally honest, the person who stayed here stayed here for only a short time. LALD-A said the licensee had an EPP. On September 3, 2024, at 3:17 p.m., during a tour of the facility with LALD-A the surveyor did not observe an EPP or any signage of the location of the EPP. In addition, surveyor did not observer any exit diagrams. On September 4, 2024, at 10:52 a.m., the facilities EPP (manual) was reviewed with	0 680			

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0 680	Continued From page 40 LALD-A. The hazard vulnerability assessment was blank and undated. LALD-A confirmed the EPP was not completed as required. LALD-A said she learned something, and she was going to "get it (EPP) cleaned up." In addition, LALD-A confirmed the licensee's missing person policy was not reviewed quarterly as required. The licensee's undated emergency preparedness plan lacked a Hazard Vulnerability Assessment and the following required content: - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - an evacuation plan customized for the facility; - shelter in place; - emergency staff strategies; - a communication plan that addressed: - names and contact information for resident physicians, - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing resident information and medical documentation; - a means to provide information regarding the facility's needs, and its ability to provide assistance, including occupancy information; and -a method of sharing information from the licensee's emergency plan with residents and their families. - EP training and testing program; - EP training program for staff (including	0 680			

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0 680	Continued From page 41 documentation of training provided); and - EP testing/annual testing requirements. On September 4, 2024, at 1:28 p.m., LALD-A confirmed there was not an exit diagram posted in the facility. LALD-A said, the "house" (facility) is not up and running. LALD-A added she "probably did have one (exit diagram) posted." R1's Assisted Living contract dated December 2, 2023, noted an emergency preparedness plan was posted in the residency for review and the emergency preparedness plan was provided to all residents at least annually. In addition, fire safety measures and an evacuation plan was posted on the information boards. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. The licensee's undated Emergency Management policy noted the facility would have an identified	0 680			

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0 680	Continued From page 42 plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or disaster that disrupts facility service. The plan considers the facility's commitment to provide service while ensuring the safety of its employees and residents. The facility would implement this Emergency Management Policy as soon as the facility became aware of the existence of an emergency. The facility conducted an analysis to identify potential emergencies and the direct and indirect effects these emergencies may have on facility operations and the demand for services. The facility would develop and maintain a written emergency management plan describing the process for disaster readiness and emergency management and implements it as appropriate. The licensee's Emergency Preparedness policy dated May 5, 2022, noted the Emergency Disaster Plan was prominently posted on each floor of the facility and included: a schematic plan of the facility or portions of the facility that shows: -evacuation routes -as applicable, smoke stop and fire doors -emergency exit diagrams -exit doors -if applicable, the location of the fire extinguishers and fire-alarm boxes. The emergency preparedness plan/program would be reviewed/updated at least annually. On initiation of assisted living, those resident with essential service needs are identified. A facility-based and community-based hazard vulnerability assessment, utilizing an all-hazards approach was completed and reviewed annually. The licensee's undated Communication Plan for Emergency Preparedness noted, as part of the facility's overall emergency disaster plan, the	0 680			

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0 680	Continued From page 43 facility would establish and maintain a communication plan that complies with Federal, State, and local laws. The licensee's undated Weather Related and Natural Disasters policy noted as part of the facility's overall emergency disaster plan, the facility would establish and maintain a plan of responding to weather related or natural disaster and would provide agency workforce members with guidance to respond during disaster. The licensee's undated Emergency Preparedness Evacuation policy noted the facility would establish and maintain guidelines planning for the evacuation of residents and the facility's office as a component of their emergency preparedness program. This is to prepare with a goal of enduring safety and mitigate harm to residents and the staff. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
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	0 700			

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0 700	Continued From page 44 by: Based on interview and record review, the licensee failed to ensure resident's personal, health, and medical information was kept from loss for one of one discharged 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 of the residents). The findings include: On September 3, 2024, at 10:35 a.m., licensed assisted living director (LALD)-A stated there had been "squatters" in the house (facility), "squatters living in the house." On September 4, 2024, at 3:26 p.m., LALD-A stated some of R1's records got destroyed. LALD-A said she had locked up R1's records in a cabinet at the facility, and "people (squatters) moved in." LALD-A said, "the people were in here and thought something of value may have been, was in, the locked cabinet and broke into it (cabinet)." LALD-A confirmed R1's records were not protected from loss. On September 4, 2024, at 3:44 p.m., clinical nurse supervisor (CNS)-C stated R1's record should have been secured and R1's personal and medical information was not protected as required. The licensee's undated Resident Records policy noted a resident record would be maintained for	0 700			

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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
0 700	Continued From page 45 every person receiving assisted living services. All resident information shall be regarded as confidential and available only to authorized users. Resident records are legal documents containing comprehensive, accurate and organized information concerning the resident's health and emotional status, and treatments and services rendered by the nurses, therapists and other health care team members. Written procedures govern use and removal of records and the conditions for release of information. A confidential clinical record containing pertinent past and current finding in accordance with accepted professional standards was maintained for every resident receiving assisting living services. Resident records, whether written or electronic, would be protected against loss, tampering or unauthorized disclosure in compliance with relevant federal an state laws. The facility would establish and implement procedures to control use, storage and security of the resident records and establish criteria for release of resident information. The facility may not disclose to any other person any personal, financial or medical information about the resident except: -as may be required by law -to employees or contractors of the facility, another facility, other health care practitioner or provider or inpatient facility needing information to provide services to the resident, but only information necessary for the provision of services -to person authorized in writing by the resident, including third-party payer, and -to representatives of the commissioner authorized to survey or investigate facilities under this license or federal laws In addition, following the resident's discharge or termination of services, an assisted living facility	0 700			

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0 700	Continued From page 46 must retain a resident's record for at least five years or as otherwise required by state and federal regulations. Arrangement must be made for secure storage and retrieval of resident records if the facility ceases to operate. The Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, noted residents have the right to have personal, financial, health, and medical information kept private. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 700			
0 730 SS=F	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;	0 730			

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0 730	Continued From page 47 (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 ensure the resident record included all required content, including documentation that services have been provided as identified in the service plan for one of one discharged resident (R1). In addition, the licensee failed to complete and provide to the resident, or their representative, or case worker, a discharge summary with the required contents for one of one discharged resident (R1). Further, the licensee failed to ensure the resident's record	0 730			

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0 730	Continued From page 48 included copies of any health care directives, guardianships, powers of attorney, or conservatorships for one of one discharged 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 of the residents). The findings include: R1's diagnoses include multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues). R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. SERVICE DOCUMENTATION On September 3, 2023, at 2:14 p.m., the surveyor requested copies of R1's record to include documentation of services provided for R1. The surveyor was given R1's contract, abuse plan, and service plan; later the surveyor received a face sheet for R1. R1's record did not include any documentation of	0 730			

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0 730	Continued From page 49 services provided. On September 4, 2023, at 3:12 p.m., clinical nurse supervisor (CNS)-C stated the licensee did not do much for R1; "Gave him food, changed (clothes), go to the bathroom, take a bath." On September 4, 2024, at 3:26 p.m., licensed assisted living director (LALD)-A stated some of R1's records got destroyed. On September 5, 2024, at 11:42 a.m., LALD-A noted in an email, "we (licensee) did not keep a sign off for laundry, meals, and housekeeping." On September 6, 2024, at 8:19 a.m., CNS-C stated she was not aware of any documentation that services were provided for R1. DISCHARGE SUMMARY R1's record did not include a discharge summary. On September 4, 2024, at 3:10 p.m., CNS-C stated a discharge summary had not been completed for R1, "he (R1) just left." On September 6, 2024, at 9:37 a.m., LALD-A said R1's record did not include a discharge summary as required. GUARDIANSHIP R1's record did not include guardianship paperwork. On September 6, 2024, at 9:10 a.m., LALD-A stated she did not have any guardianship paperwork for R1. On September 6, 2024, at 9:52 a.m., R1's family member (FM-G) and stated by LALD-A as R1's	0 730			

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0 730	Continued From page 50 guardian, said he wanted to make sure R1 was doing "his stuff (personal cares.)" FM-G said R1 had dementia, short term, from a stroke R1 had and MS. FM-G stated R1 had been falling. FM-G added R1 refused to sign paperwork, so FM-G signed. FM-G added, "They (licensee) were helping me out." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0120, Subp. 9, effective October 2022, at the time of discharge, the facility must provide the resident, and, with the resident's consent, the resident's representatives, and case manager, with a written discharge summary that includes all content as applicable in sections A.-D. The licensee's undated Resident Records policy noted a resident record would be maintained for every person receiving assisted living services. Contents of resident records included the following for each resident: -copies of any health care directives, guardianships, powers of attorney, or conservatorships -the facility's current and previous assessments -all records of communications pertinent to the resident's services -documentation of significant changes in the resident status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional -the 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 -documentation that services had been provided as identified in the service plan -a discharge summary, including service	0 730			

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0 730	Continued From page 51 termination notice and related documentation when applicable; and -other documentation required under this license and relevant to the resident's services. The licensee's undated Resident Discharge Process policy noted a copy of the discharge summary was filed in the resident record. 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 the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code,	0 780			

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0 780	Continued From page 52 except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. 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 September 04, 2024, from approximately 12:24 p.m. to 1:15 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. Survey staff was unable to test the smoke alarms due to the house being under construction. The smoke alarm in two of the bedrooms on the main floor were not working, the other bedroom on the main floor did not have a smoke alarm and did not have a smoke alarm provided outside and in the immediate vicinity of this bedroom. The upstairs bedroom smoke alarm could not be tested if it was working or not. The basement had smoke alarms but were hanging by wires and not yet operational.	0 780			

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0 780	Continued From page 53 These deficient conditions were visually verified by LALD-A accompanying on the tour. On September 04, 2024, at 12:30 p.m., LALD-A stated that the facility is currently under construction and the contractor is working on getting the smoke alarms operational. LALD-A stated they understood the smoke alarm requirements. No further information was provided. 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. This deficient condition had the potential to affect all staff, residents, and visitors.	0 790			

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0 790	Continued From page 54 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 04, 2024, at approximately 12:30 p.m. to 1:35 p.m., survey staff conducted a facility tour with licensed assisted living director (LALD)-A, survey staff observed that there were no fire extinguishers throughout the facility and that they did not have documentation of yearly and monthly inspections. LALD-A stated they understood the requirements and that the facility is currently under construction with no residence. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800			

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0 800	Continued From page 55 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 4, 2024, from approximately 12:15 p.m. to 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. The following was observed: The dining room wall by the window had a crack in it. The main-floor and upstairs bathroom had the walls filled in with drywall spackling and needed paint. The light and electrical outlet covers are off throughout all the rooms in the house. The carpet and flooring had been torn up	0 800			

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0 800	Continued From page 56 throughout the house leaving only remnants of carpet pad and exposed subfloor. LALD-A stated this was due to having "squatters" and they destroyed the property, and she could not get them out. The basement wall and ceiling finishes had been torn off and leaving only exposed wood framing and electrical. It appeared that new wall and ceiling framing was being installed. LALD-A stated that there was not going to be any bedrooms in the basement. The furnace room in the basement had standing water in it. LALD-A not sure where the water was coming in from. The bottom step going up to the front door was cracked creating an uneven walking surface. Walking surfaces used by residents and visitors must be maintained and properly installed, secure, and not create possible tripping hazards. The egress window in the upstairs bedroom had a broken window crank and LALD-A could not open the window. On September 4, 2024, at 1:30 p.m., LALD-A stated they understood the above-listed deficiencies. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810			

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0 810	Continued From page 57 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training and drills. This had the potential to directly affect all residents, staff, and visitors.	0 810			

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0 810	Continued From page 58 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 September 04, 2024, at approximately 1:15 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: LALD-A was unable to provide any Fire Safety and evacuation plans or map. LALD-A stated there currently are no residents and was unable to provide these documents. DRILLS: The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-A was unable to provide these documents and stated that she was unaware they were supposed to be doing the drills even though there are no residents. TRAINING: The licensee failed to provide evacuation training to residents and staff. The LALD-A stated that there are no residents or staff currently at this facility, so training has not been done.	0 810			

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0 810	Continued From page 59	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. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some 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	0 820			

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 3350 JAMES AVENUE N MINNEAPOLIS, MN 55412			
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0 820	Continued From page 60 of the residents). The findings include: On September 04, 2024, from approximately 12:30 p.m. to 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. During the tour, survey staff explained to the LALD-A the noncompliant measurements. UNOCCUPIED SLEEPING ROOMS: Bedroom on main floor to the left of the hallway: Window measured 29 inches clear width, 19.5 inches clear height, and 565.5 square inches total open area. Bedroom on main floor to the right of the hallway: Window measured 22.75 inches clear width, 19.5 inches clear height, and 444 square inches total open area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 820			
0 830 SS=F	144G.45 Subd. 3 Local laws apply	0 830			

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0 830	Continued From page 61 Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to comply with all state and local governing laws, and codes for fire safety, building, and zoning requirements. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 04, 2024, from approximately 12:15 p.m. to 1:30 p.m., survey staff toured the facility with licensed assisted living director (LALD)-A. At the time of the survey, the entire facility was under various forms of construction. LALD-A stated that they had to renovate throughout the whole facility due to squatters occupying the facility and lack of maintenance. LALD-A was not able to provide a floorplan at the time of survey, so the extent of construction/renovation was not able to be determined. Building permits and approvals and MDH approvals for renovation were not able to be	0 830			

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0 830	Continued From page 62 provided. Facilities undergoing construction and renovation must get proper approvals from MDH and MN DLI or local building authority prior to starting construction or renovation. LALD-A stated she understood no residents could occupy the house and stated there were no plans to move anyone into that space until it was finished. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 830			
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (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	0 900			

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0 900	Continued From page 63 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 have a signed assisted living contract for one of one discharged 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 of the residents). The findings include: R1 was admitted to the facility on December 5, 2023. R1's diagnoses include multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues). R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care (daily prompting)	0 900			

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0 900	Continued From page 64 -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. R1's undated "exhibit 1: Designation of Representative" form was signed by R1's family member (FM-G). R1's Assisted Living Contract, dated December 2, 2023, was signed, "guardian signed". On September 6, 2024, at 9:11 a.m., LALD-A stated R1's contract noted, "guardian signed." LALD-A confirmed R1's contract was not signed by guardian, adding "I don't know why? guardian signed everywhere else." The licensee's undated Assisted Living Contracts policy noted the resident must agree in writing to any additions or amendments to the contract. An addendum to existing contract must be executed and signed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law.	0 970			

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0 970	Continued From page 65 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the ability to impact all residents who have signed an assisted living contract. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to the facility on December 5, 2023. R1's Assisted Living Contract, noted "signed by guardian," dated December 2, 2023, included: -"Indemnification: [licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [licensee] harmless from any claims or damages unless caused solely by negligence of [licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." -"Liability: The resident agrees to be liable and	0 970			

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0 970	Continued From page 66 responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." Additional Services -7."Security/Valuables/Keys: All resident rooms have security locks. If you choose not to lock your valuables, you assume liability for them." On September 4, 2024, at 11:36 a.m., licensed assisted living director (LALD)-A stated she was aware of the liability clause and thought we (licensee) had to (have a clause), sometimes you have to (have a clause), if they (residents) wreck things. LALD-A then stated a correction order had been written at another site also, so the contract had been changed. The licensee's undated Assisted Living Contracts policy noted the contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful or unenforceable under state or federal law. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
0 980 SS=C	144G.51 ARBITRATION (a) An assisted living facility must clearly and	0 980			

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0 980	Continued From page 67 conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action. (b) An arbitration requirement must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include an arbitration provision for one of one discharged resident (R1). 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 the potential to affect a large portion or all the residents). The findings include: R1 was admitted to the facility on December 5, 2023. R1's Assisted Living contract signed by licensed assisted living director (LALD)-A on December 2, 2023, and noted "guardian signed" on resident signature line included: - the resident will pay a late payment fee in an amount indicated in the Schedule of Fees for any month in which the entire current balance due was not paid by the fifteenth calendar day of the month due. The resident would pay all costs and	0 980			

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0 980	Continued From page 68 expense, including reasonable attorney's fees and court costs, incurred by the licensee in collecting amounts past due under this agreement. On September 6, 2024, at 9:15 a.m., the surveyor reviewed R1's contract with LALD-A. LALD-A stated they (licensee) paid for the contract and lawyers had reviewed the contract. LALD-A added, things get frustrating as they were surveyed at another facility, and the only thing they were made aware of was the liability clause that had been removed. LALD-A agreed the clause in the contract may prevent action from being taken by a resident. The licensee's undated Assisted Living Contracts policy noted the facility must disclose in writing in the contract any arbitration provision that precludes, limits, or delays the ability of a resident from taking civil action. An arbitration requirement must not include a choice of lawyer or choice of venue provision. Contracts must adhere to Minnesota Law and any other applicable federal or local law. No further information was provided. TIME PERIOD OF CORRECTION: Twenty-One (21) Days	0 980			
01290 SS=F	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	01290			

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01290	Continued From page 69 construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for four of four employees (unlicensed personnel (ULP)-B, ULP-D, ULP-E, 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) 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 3, 2024, at approximately 1:45 p.m., the surveyor requested background studies for the licensee's employees. On September 3, 2024, at 2:16 pm., licensed assisted living director (LALD)-A stated she would look for background studies for the employees who worked for the licensee, but added she did not know "I (LALD-A) had to single them out"	01290			

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01290	Continued From page 70 [background studies/affiliations for this Health Facility Identification Number (HFID)]. On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor the facility's "staffing plan" which consisted of five pages, titled with the licensee's name and address. Pages were dated December 5, 2023, through January 5, 2024. -ULP-B's name was listed on the schedule several times, to include December 9, 2023, through December 11, 2023, from 7:00 p.m. until 7:00 a.m., and January 2, 2024, through January 5, 2024, from 7:00 p.m. until 7:00 a.m. -ULP-D's name was listed on the schedule several times, to include December 9, 2023, through December 11, 2023, 7:00 a.m. until 7:00 p.m., and January 2, 2024, through January 5, 2024, 7:00 a.m. until 7:00 p.m. -ULP-E's name was listed on the schedule several times, to include December 5, 2023, through December 8, 2023, 7:00 a.m.,until 7:00 p.m., and January 2, 2024, through January 5, 2024, 7:00 a.m. until 7:00 p.m., and December 30, 2023, through January 1, 2024 -ULP-F's name was listed on the schedule several times, to include December 5, 2023, through December 8, 2023, 7:00 p.m., until 7:00 a.m., and December 30, 2023, through January 1, 2024, 7:00 p.m., until 7:00 a.m. ULP-B ULP-B was hired on August 9, 2022, to provide direct care services to the licensee's residents. On September 5, 2024, at approximately 12:00 p.m., LALD-A provided the surveyor with a background study notice for ULP-B, for HFID 25977, dated November 20, 2022. The NETStudy roster, obtained September 6,	01290			

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01290	Continued From page 71 2024, at 12:51 p.m., noted ULP-B had an affiliation date of January 1, 2023, and a separation date of October 18, 2023, was separated from HFID 36467. On the form ULP-B had been affiliated with two other HFID numbers, however at the time of employment at HFID 36467 ULP-B was not affiliated with any of the licensee's facilities. ULP-B did not have a background study for HFID 36467 at the time of his employment for the licensee, as required. ULP-D ULP-D was hired on April 19, 2019, to provide direct care services to the licensee's residents. The NETStudy 2.0 roster, obtained September 6, 2024, at 12:51 p.m., indicated a background study had not been completed for ULP-D. ULP-E ULP-E was hired on December 2, 2019, to provide direct care services to the licensee's residents. The NETStudy 2.0 roster, obtained September 6, 2024, at 12:51 p.m., indicated a background study had not been completed for ULP-E. ULP-F ULP-F was hired on October 9, 2020, to provide direct care services to the licensee's residents. The NETStudy 2.0 roster, obtained September 6, 2024, at 12:51 p.m., indicated a background study had not been completed for ULP-F. On September 6, 2024, at 9:10 a.m., LALD-A stated staff worked their schedule, so, yes, ULPs worked with R1 while alone.	01290			

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01290	Continued From page 72 On September 6, 2024, at 10:35 a.m., LALD-A said the licensee had been cited during another survey for background studies. When the surveyor brought it to LALD-A's attention ULP-B, ULP-D, ULP-E, ULP-F's background studies were not completed as required she replied, "hmm." The licensee's undated Background Studies policy noted each facility employee/volunteer or contractor who would provide direct care to residents must have a background study completed. The forms would be completed at the time of hire. Employees may not work until the results of the background study had been received. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01460 SS=D	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure orientation to assisted living licensing requirements and regulations was	01460			

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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
01460	Continued From page 73 completed for one of two employees (clinical nurse supervisor (CNS)-C). This had the potential to affect all residents. 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: CNS-C was hired on February 20, 2020, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On September 3, 2024, at 1:13 p.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility. CNS-C's employee record lacked orientation to assisted living requirements at the time of hire to include: -an overview of chapter 144G.08 through 144G.93 -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -handling of emergencies and use of emergency services -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC)	01460			

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01460	Continued From page 74 -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -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 -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On September 4, 2024, at 3:37 p.m., LALD-A stated as a question, "the trainer needs to be trained?" LALD-A confirmed orientation had not been completed for CNS-C. CNS-C said, "ah, yes, like CEUs (continuing education units)." On September 5, 2024, at 12:13 p.m., the surveyor received an email from LALD-A which noted: "We do not have any training for our nurse. She's the one that does the training. We've never been asked for training for her. Not even at our other two surveys. Can you send me the statue for the nurse training requirements. I've scanned the entire regulation book and cannot find it! " On September 6, 2024, at 8:37 a.m., CNS-C stated she keeps up her CEUs, but she did not receive training from the licensee.	01460			

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01460	Continued From page 75 The licensee's undated Qualifications, Training and Competency policy noted facility shall provide training to all staff providing and supervision assisted living services at the time of hires, and as needed to meet state guidelines and quality standards. The licensee's undated Facility Employee Orientation policy noted the stated required orientation to home care home include: -overview of Minnesota's home care law -an introduction and review of all the facility's policies and procedures related to the provision of services -handling of emergencies and use of emergency services -reporting the maltreatment of vulnerable minors or adults under Minnesota Statues -the home care bill of rights -a review of the types of services the employee would be providing and the scope of the facility's services under the specific license -completion of the orientation training shall be documented in the employee's personnel file. The Minnesota Bill of Rights for Assisted Living dated July 17, 2024, noted residents have the right to care and assisted living services with continuity from people who are properly trained and competent to perform their duties. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460			
01470 SS=F	144G.63 Subd. 2 Content of required orientation	01470			

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01470	Continued From page 76 (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 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	01470			

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01470	Continued From page 77 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 licensee failed to ensure employees received orientation to assisted living licensing requirements and regulations prior to providing services for one of one employee (unlicensed personnel (ULP)-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-B was hired on August 9, 2022, to provide direct care services to the licensee's residents.	01470			

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01470	Continued From page 78 On September 4, 2024, at 12:20 p.m., licensed assisted living director (LALD)-A gave the surveyor the facility's "staffing plan" which consisted of five pages, titled with the licensee's name and address. ULP-B's name was listed on the schedule several times, including December 9, 2023, through December 11, 2023, from 7:00 p.m. until 7:00 a.m., and January 2, 2024, through January 5, 2024, from 7:00 p.m. until 7:00 a.m. ULP-B's employee record lacked documented evidence of the following requirement: - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On September 6, 2024, at 9:27 a.m., LALD-A stated she was trying to think. LALD-A said she was not aware that the communication training did not cover person centered planning and service delivery. LALD-A confirmed the training was not completed as required, and added the correction would be made. The licensee's undated Qualifications, Training and Competency policy noted facility shall provide training to all staff providing and supervision assisted living services at the time of hires, and as needed to meet state guidelines and quality standards. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training	01500			

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01500	Continued From page 79 (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research	01500			

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01500	Continued From page 80 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 employees received all required content of annual training for each 12 months of employment for two of two employees (clinical nurse supervisor (CNS)-C, 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: CNS-C CNS-C was hired on February 20, 2020, to	01500			

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01500	Continued From page 81 provide direct care and services to the licensee's residents and oversight of the licensee's employees. On September 3, 2024, at 1:13 p.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility. CNS-C's employee record lacked evidence CNS-C successfully completed eight hours of annual training as required to include: -a review of the Bill of Rights for Assisted Living -reporting maltreatment of vulnerable adults or minors -review of infection control techniques -effective approaches to use to problem solve when working with resident's challenging behaviors -the principles of person-centered planning and service delivery -a review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures. On September 3, 2024, at 2:23 p.m., LALD-A stated "why does a nurse need annual training? She (CNS-C) is a nurse." On September 5, 2024, at 12:13 p.m., the surveyor received an email from LALD-A which noted: "We do not have any training for our nurse. She's the one that does the training. We've never been asked for training for her. Not even at our other two surveys. Can you send me the statute for the nurse training requirements. I've scanned the entire regulation book and cannot find it! " On September 6, at 9:31 a.m., CNS-C stated she	01500			

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01500	Continued From page 82 did not receive annual training at the facility by the licensee. ULP-D ULP-D was hired on April 19, 2019, to provide direct care services to the facility's residents. ULP-D's employee record lacked evidence ULP-D successfully completed annual training as required to include: -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On September 6, 2024, at 9:27 a.m., LALD-A stated she was trying to think. LALD-A said she was not aware that the communication training did not cover person centered planning and service delivery. LALD-A confirmed the training was not completed as required and added the correction would be made. The licensee's undated Annual Training Requirements policy noted all staff that provide direct care services in assisted living must complete at least eight hours of annual training for each 12 months of employment. Annual training must include: -training on reporting of maltreatment of vulnerable adults under section 626.557 -review of the Assisted Living Bill of Rights and staff responsibilities related to ensure the exercise and protection of those rights -review of infection control techniques used in the home and implementation of infection control stands including: a review of hand-washing techniques, need for and use of protective gloves, gowns, and masks, appropriate disposal of contaminated materials and equipment, such as dressing, needle, syringes, and razor blades,	01500			

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01500	Continued From page 83 disinfecting reusable equipment, disinfecting environmental surfaces, reporting of communicable disease's -effective approaches to use problem solve when working with a resident's challenging behaviors, and how to communicate with resident's who have dementia, Alzheimer's disease or related disorders -review of the facility's policies and procedures relating to provision of assisted living services and how to implement those policies and procedures -the principles of person-centered planning and service deliverer and how they apply to direct support services provided by the staff person. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500			
01530 SS=D	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	01530			

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01530	Continued From page 84 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 one of two employees, (clinical nurse supervisor CNS-C) received the required amount of dementia care training in the required time frame. 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: CNS-C was hired on February 20, 2020, to provide direct care and services to the licensee's residents and oversight of the licensee's employees. On September 3, 2024, at 1:13 p.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility.	01530			

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01530	Continued From page 85 CNS-C's employee record did not indicate a total of eight hours of the required dementia training was completed within 120 hours of the employee's start date, or two hours annually as required. On September 5, 2024, at 12:13 p.m., the surveyor received an email from LALD-A which noted: "We do not have any training for our nurse. She's the one that does the training. We've never been asked for training for her. Not even at our other two surveys. Can you send me the statute for the nurse training requirements. I've scanned the entire regulation book and cannot find it! " The licensee's undated Dementia Care Training policy noted the facility provided required dementia training to all direct care staff and their supervisors and made appropriate disclosures to resident's and resident representatives who requested the information. All supervisors of direct-care staff must have at least eight hours of initial training within 120 working hours of employment start date and must have at least two hours of training on topics related to dementia are for each 12 months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01530			
01560 SS=F	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED (5) new employees may satisfy the initial training requirements by producing written proof of	01560			

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01560	Continued From page 86 previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure dementia training included all the required content for two of two employees (clinical nurse supervisor (CNS)-C, unlicensed personnel (ULP)-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) 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: CNS-C was hired on February 20, 2020, to provide direct care and services to the licensee's residents and oversight of the licensee's employees.	01560			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36467	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/06/2024
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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
01560	Continued From page 87 On September 3, 2024, at 1:13 p.m., licensed assisted living director (LALD)-A stated CNS-C was the CNS for the facility. CNS-C's employee record lacked evidence CNS-C received the following dementia training: -the explanation of Alzheimer's disease and other dementia -assistance with activities of daily living -communication skills -person-centered planning and service delivery. On September 5, 2024, at 12:13 p.m., the surveyor received an email from LALD-A which noted: "We do not have any training for our nurse. She's the one that does the training. We've never been asked for training for her. Not even at our other two surveys. Can you send me the statue for the nurse training requirements. I've scanned the entire regulation book and cannot find it! " ULP-B ULP-B was hired on August 9, 2022, to provide direct care services to the licensee's residents. to provide direct care services to the licensee's residents. On September 4, 2024, at 12:20 p.m., LALD-A gave the surveyor the facility's "staffing plan" which consisted of five pages, titled with the licensee's name and address. ULP-B's name was listed on the schedule several times, including December 9, 2023, through December 11, 2023, from 7:00 p.m. until 7:00 a.m., and January 2, 2024, through January 5, 2024, from 7:00 p.m. until 7:00 a.m. ULP-B's employee record included dementia training:	01560			

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01560	Continued From page 88 -an overview of the causes -progression and triggers -effective interventions -effective interventions in ADLs (activities of daily living) -interventions for losses in brain function -working with families of clients with dementia. ULP-B's employee record lacked evidence ULP-B received the following dementia training: -person centered planning and service delivery. On September 5, 2024, at approximately 2:15 p.m., dementia training done by the licensee was reviewed with LALD-A. LALD-A stated she thought what dementia training was done met the requirements. On September 6, 2024, at 9:27 a.m., LALD-A said she was not aware that the communication training did not cover person centered planning and service delivery. LALD-A confirmed the training was not completed as required and added a correction would be made. The licensee's undated Dementia Care Training policy noted areas of required training included: -an explanation of Alzheimer's Disease and other dementia's -assistance with activities of daily living -problem solving with challenging behaviors -communication skills -person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560			

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01610	Continued From page 89	01610			
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed an initial, comprehensive nursing assessment prior to signing the assisted living contract/providing services for one of one discharged 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 of the residents).	01610			

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01610	Continued From page 90 The findings include: During the entrance conference on September 3, 2024, at 1:18 p.m., licensed assisted living director (LALD)-A stated, "my nurse (clinical nurse supervisor/CNS-C) does assessments, adding "we all do." LALD-A said she had it broken down (assessment schedule) if she (LALD-A) could find it. LALD-A called CNS-C about assessment schedule. CNS-C said she comes in when called, within five days, at two weeks, and 90 days. CNS-C said she also does assessments if hospitalized or when there is a change in condition. R1 was admitted to the facility on December 5, 2023. R1's record included an assisted living contract dated December 2, 2023. R1's diagnoses include multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues). R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. On September 6, 2024, at 9:52 a.m., R1's family member (FM-G) stated R1 had dementia, short term, from a stroke, and MS. In addition, FM-G stated R1 had been falling, and R1 was paranoid	01610			

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01610	Continued From page 91 and would not take medication or eat some foods, adding, R1 thought something was put into R1's food. On September 4, 2024, at 3:07 p.m., CNS-C stated R1 did not want assessments done, adding R1 was "non-compliant." CNS-C then said, yes, she did assessments, on paper, however she was not sure where the assessments went, as they were completed before computer system was used. On September 5, 2024, at 11:42 p.m., per email communication, LALD-A noted "we did do some paperwork prior, but he (R1) didn't come on that date," and R1 "would not participate in the initial assessment." The licensee had no evidence of any assessments being completed. On September 6, 2024, at 8:20 a.m., CNS-C stated she could not remember the date she completed an assessment for R1. CNS-C said R1 was already living at the facility, and no assessment had been completed prior. On September 6, 2024, at 8:23 a.m., CNS-C stated "they" (LALD-A/licensee) told "me" (CNS-C) about R1. They (LALD-A) said R1 was not compliant, and he (R1) was just be there briefly. CNS-C stated R1 had a lot of paranoia, that was the problem. CNS-C said, "I was telling them, he (R1) needed some mental help." CNS-C added, "usually they (licensee) give me paperwork, "we don't have staff to handle this, we don't want to play games with people's lives. He (R1) was more or less self-destructive." CNS-C added, "when I asked if we are taking care of this guy or not, no doctor, he did not want anything from anyone, hands off. I felt like what are we really doing for this guy, let us put him in the	01610			

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01610	Continued From page 92 system, because he was not agreeable." CNS-C stated R1 was a family member, however she was not sure who's family. They (licensee) told her after he was there, they were going to monitor him and see." CNS-C said R1 was private pay, and she never talked to R1's guardian. CNS-C confirmed she met R1 after he was living there. CNS-C said she went to the facility "once and a while" to go check on him. CNS-C said, "of course I do assessments with "regular" residents. R1 just came in, "just wanted to monitor and see if he (R1) would agree and get health checks. CNS-C said she "kept asking questions. Is he (R1) eating? Is he (R1) in pain?" CNS-C said R1 refused Tylenol. CNS-C confirmed an assessment was not completed prior to R1's arrival, or at the time of his arrival. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's undated Comprehensive Resident	01610			

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01610	Continued From page 93 Assessment policy noted the facility would complete a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610			
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			

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01620	Continued From page 94 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool within 14 days for one of one discharged 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 of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:18 p.m., licensed assisted living director (LALD)-A stated, "my nurse (clinical nurse supervisor/CNS-C) does assessments, adding "we all do." LALD-A said she had it broken down (assessment schedule) if she (LALD-A) could find it. LALD-A called CNS-C about assessment schedule. CNS-C said she comes in when called, within five days, at two weeks, and 90 days. CNS-C said she also does assessments if hospitalized or when there is a change in condition. R1's diagnoses include multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues). R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care,	01620			

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01620	Continued From page 95 bathing/shower, shampoo, nail care, skin care (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. On September 6, 2024, at 9:52 a.m., R1's family member (FM-G) stated R1 had dementia, short term, from a stroke, and MS. In addition, FM-G stated R1 had been falling, and R1 was paranoid and would not take medication or eat some foods, adding, R1 thought something was put into R1's food. 14-DAY ASSESSMENT On September 4, 2024, at 3:07 p.m., CNS-C stated assessments were not completed for R1. CNS-C stated R1 was non-compliant, and he did not want assessments completed. CNS-C then stated yes, assessments were completed for R1, on paper, but she was not sure where they (assessments) were, adding the assessments were done prior to having a computer system in place. On September 6, 2024, at 8:20 a.m., CNS-C stated she could not remember the date she completed an assessment for R1. CNS-C said R1 was already living at the facility, and no assessment had been completed prior. On September 6, 2024, at 8:23 a.m., CNS-C stated "they" (LALD-A) told "me" (CNS-C) about R1. They (LALD-A) said R1 was not compliant, and he (R1) was just being there briefly. CNS-C stated R1 had a lot of paranoia, that was the problem. CNS-C said, "I was telling them, he (R1) needed some mental help." CNS-C added "usually they (licensee) give me paperwork, "we don't have staff to handle this, we don't want to	01620			

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01620	Continued From page 96 play games with peoples life. He (R1) was more or less self-destructive." CNS-C added, "when I asked if we are taking care of this guy or not, no doctor, he did not want anything from anyone, hands off. I felt like what are we really doing for this guy, let us put him in the system, because he was not agreeable." CNS-C stated R1 was a family member, however she was not sure who's family. They (licensee) told her after he was there, they were going to monitor him and see." CNS-C said R1 was private pay, and she never talked to R1's guardian. CNS-C confirmed she met R1 after he was living there. CNS-C said she went to the facility "once and a while" to go check on him. CNS-C said, "of course I do assessments were "regular" residents, R1 just came in, "just wanted to monitor and see if he (R1) would agree and get health checks. CNS-C said she "kept asking questions, is he (R1) eating? Is he in pain?" CNS-C said R1 was refusing Tylenol. CNS-C stated she did attempt to complete an assessment once he was at the facility, however R1 was not compliant, and she was not sure of the date. CNS-C confirmed R1's record lacked a 14-day assessment. ASSESSMENT TOOL On September 5, 2024, at 11:12 a.m., LALD-A provided the surveyor with a Nursing-Comprehensive Assessment (non-skilled care) which was blank other than R1's name and the paper was assessment dated, December 5, 2023. The assessment included: -clinical record items: vital signs -sensory status: eyes, ears, nose, throat, and mouth, pain -integumentary system: lesions, wounds or ulcers -cardiac assessment -respiratory status	01620			

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01620	Continued From page 97 -genitourinary system -gastrointestinal/nutritional status -endocrine system -neuro/behavior/mental status -psychosocial assessment -musculoskeletal assessment -appliances/equipment. On September 6, 2024, at 8:22 a.m., CNS-C stated assessment tools used were individualized. On September 6, 2024, at 9:38 a.m., the surveyor reviewed the assessment tool which would have been used for R1 with LALD-A. LALD-A confirmed the assessment tool did not include all of the items on the universal tool: dressing, grooming, bathing, personal hygiene, ability to self-mange medications, housework/laundry, transportation, sensitive to medication, environment, infections conditions, review of medications, interventions needed to prevent diversion of medication, a review of medical, dental and emergency room visits in the past 12 monitions, visits to primary health care provider, surgeries, nutritional and hydration status and preferences, risk of falls, emergency evacuation ability, alcohol and drug use, smoking, elopement risk, etc. In addition, LALD-A confirmed the assessment tool did not include a cognitive assessment of a prospective resident. LALD-A said, "we (licensee) don't use that tool anymore, adding Rtask (computer system) is now used." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident	01620			

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01620	Continued From page 98 receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's undated Comprehensive Resident Assessment policy noted the facility would complete a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior of the date that a prospective resident executes a contract with a facility or the day the resident moves in, whichever is earlier. Resident assessment and monitoring must be conducted no more than 14 days after initiation of services. On-going resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident. All assessments would be included in the resident record. For resident's receiving assisted living services specified in section 144G.08, Subd. 9, 1-5, the facility would complete an individualized initial review of the resident's needs and preferences. These services are: -assist with dressing, self-feeding, oral hygiene, hair care, grooming, toileting and bathing -providing standby assistance. No further information was provided.	01620			

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01620	Continued From page 99	01620			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days				
01630 SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the temporary service plan for one of one discharged resident (R1) was in effect for less than three days. 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: During the entrance conference on September 3, 2024, at 1:21 p.m., licensed assisted living director (LALD)-A stated the registered nurse (RN/clinical nurse supervisor (CNS)-C) completed service plans. R1 was admitted to the facility on December 5, 2023.	01630			

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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
01630	Continued From page 100 R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. On September 5, 2024, at 11:42 a.m., LALD-A noted in an email, "we did do some paperwork prior, but he (R1) didn't come on that date." R1's record included the service plan dated December 2, 2023, which was effective for more than 72 hours. R1's record lacked an updated service plan as required. On September 4, 2024, at 3:25 p.m., R1's service plan was reviewed with CNS-C. CNS-C stated it was fair to say that R1's service plan had not been updated as required. On September 6, 2024, at 8:19 a.m., CNS-C stated she did not complete R1's service plan. The licensee's undated Service Plan policy noted the service plan, and any revision must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the service to be provided. A temporary service plan would not be effective for more than 72 hours. A service plan shall be finalized with each resident no later than 14 calendar days after the start of service. If services are initiated prior to the completion of a comprehensive assessment by the registered nurse or other licensed health professional, the temporary service plan would be developed in accordance with accepted	01630			

Minnesota Department of Health

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01630	Continued From page 101 standards of practice. When the assessment was completed the initial service plan is established. The service plan is based on the assessment and resident preferences and is consistent with accepted stands of practice for professional nursing or other relevant standards. Changes in types of services or fees would be based on assessment of the resident or resident preferences and reviewed with the resident/representative and noted on the service plan as appropriate. All changes in the service plan must be acknowledged by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630			
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,	01640			

Minnesota Department of Health

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01640	Continued From page 102 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 interview and record review, the licensee failed to ensure a service plan was updated to include provided services for one of one discharged 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 of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:21 p.m., licensed assisted living director (LALD)-A stated the registered nurse (RN/clinical nurse supervisor (CNS)-C) completed service plans. R1's diagnoses include multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues.) R1 was admitted to the facility on December 5, 2023. R1's service plan dated December 2, 2023, indicated R1 received the following services:	01640			

Minnesota Department of Health

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01640	Continued From page 103 -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. R1's Schedule of Fees, exhibit three of service plan dated December 2, 2023, noted there was no addition daily fees for meals, breakfast, lunch, dinner. On September 4, 2024, at 8:24 a.m., the surveyor received an email from LALD-A that noted, "in a sense, he (R1) received services because he (R1) got 24-hour supervision and assistance with ADLs (activities of daily living); prompting, cueing, and making sure he (R1) bathed, and groomed. No hands-on assistance was needed, and he (R1) didn't take medications so we (licensee) didn't keep a MAR (medication administration record)." On September 4, 2024, at 2:06 p.m., LALD-A stated, he (R1) did his own medications and his own food. They (staff) came to check, they did not stay here. They (staff) should of, not sure if staff stayed at the facility. On September 4, 2023, at 3:12 p.m., CNS-C stated the licensee did not do much for R1. "Gave him food, changed (clothes), go to the bathroom, take a bath." On September 4, 2024, at 3:14 p.m., LALD-A stated, "they" (licensee) gave R1 food, "from outside, from family or something. We made sure he was eating; we did not do any food in here." LALD-A added "we did not cook."	01640			

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01640	Continued From page 104 On September 4, 2024, at 3:25 p.m., R1's service plan was reviewed with CNS-C. CNS-C stated it was fair to say that R1's service plan had not been updated as required. On September 5, 2024, at 11:42 a.m., LALD-A noted in an email, "we (licensee) did not keep a sign off for laundry, meals, and housekeeping." On September 6, 2024, at 8:19 a.m., CNS-C stated she did not complete R1's service plan. On September 6, 2024, at 9:52 a.m., R1's family member (FM-G) stated he wanted to make sure R1 was doing "his stuff." FM-G said R1 had dementia, short term, from a stroke he had and MS. R1's guardian stated R1 had been falling. FM-G added R1 refused to sign so he did and added staff were there all the time. "They were helping me out." The licensee's undated Service Plan policy noted the service plan, and any revision must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the service to be provided. A temporary service plan would not be effective for more than 72 hours. A service plan shall be finalized with each resident no later than 14 calendar days after the start of service. If services are initiated prior to the completion of a comprehensive assessment by the registered nurse or other licensed health professional, the temporary service plan would be developed in accordance with accepted standards of practice. When the assessment was completed the initial service plan is established. The service plan is based on the assessment and resident preferences and is consistent with accepted stands of practice for professional	01640			

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01640	Continued From page 105 nursing or other relevant standards. Changes in types of services or fees would be based on assessment of the resident or resident preferences and reviewed with the resident/representative and noted on the service plan as appropriate. All changes in the service plan must be acknowledged by the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650			

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01650	Continued From page 106 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included the required content for one of one discharged 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 of the residents). The findings include: During the entrance conference on September 3, 2024, at 1:21 p.m., licensed assisted living director (LALD)-A stated the registered nurse (RN)/clinical nurse supervisor (CNS-C) completed service plans. R1's diagnoses include multiple sclerosis (MS/central nervous system autoimmune condition, damage to myelin causing symptoms like muscle weakness, vision changes, numbness, and memory issues). R1's service plan dated December 2, 2023, indicated R1 received the following services: -assistance with grooming: oral care, bathing/shower, shampoo, nail care, skin care	01650			

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01650	Continued From page 107 (daily prompting) -homemaker interventions: remove garbage, monitor foods for freshness, clean bedroom, change lines, laundry, vacuum, dust. R1's service plan included "when to notify RN: "omitted (N/A)" was hand written in after a line that had been crossed out. In addition, the service plan was not signed by a RN, there was a date of December 2, 2023. R1's service plan did not include the following required content: -the methods of monitoring staff providing services -the frequency of each service provided -the identification of staff or categories of staff would would provide the services -information when to contact the facility, RN/CNS-C. On September 4, 2024, at 11:13 a.m., R1's service plan was reviewed with LALD-A. LALD-A stated R1's service plan was lacking the required information to include a method of review for staff, frequency of services, and who would provide services. On September 6, 2024, at 9:10 a.m., LALD-A stated an error was made on R1's service plan, when to call nurse. LALD-A also confirmed R1's service plan was not authenticated d by CNS-C, and LALD-A had signed her name but not included her title on the form. The licensee's undated Service Plan policy noted the service plan was include: -a description of the services to be provided -the staff or categories of staff that would provide the services -the type and frequency of visits/services	01650			

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01650	Continued From page 108 proposed to be furnished according to the resdient's current review/assessment and resident preferences -the fees for services -the schedule and methods of monitoring staff proving services No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650			
02430 SS=F	144G.91 Subd. 15 Confidentiality of records (a) Residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Residents must be notified when personal records are requested by any outside party. (b) Residents have the right to access their own records. This MN Requirement is not met as evidenced by: Based on interview and record, review the licensee failed to ensure resident's personal health and medical information was kept confidential for one of one discharged 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	02430			

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02430	Continued From page 109 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 3, 2024, at 10:35 a.m., licensed assisted living director (LALD)-A stated there had been "squatters" in the house (facility), "squatters living in the house." On September 4, 2024, at 3:26 p.m., LALD-A stated, she had locked up R1's records in a cabinet at the facility, and "people (squatters) moved in." LALD-A said, "the people were in here and thought something of value may have been/ was in, the locked cabinet and broke into it (cabinet)." LALD-A confirmed R1's records were not kept confidential, as the cabinet which housed R1's records was destroyed and access was gained to R1's records by the people swatting at the facility. On September 4, 2024, at 3:44 p.m., clinical nurse supervisor (CNS)-C stated R1's record should have been secured and R1's personal and medical information was kept private as required. On September 5, 2024, the surveyor received an email from LALD-A that noted, "I have to say again that this location was set up like our other locations prior to our squatter experience. Which was horrible and exhausting as hell!" The licensee's undated Resident Records policy noted a resident record would be maintained for every person receiving assisted living services. All resident information shall be regarded as confidential and available only to authorized users. Resident records are legal documents	02430			

Minnesota Department of Health

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02430	Continued From page 110 containing comprehensive, accurate and organized information concerning the resident's health and emotional status, and treatments and services rendered by the nurses, therapists and other health care team members. Written procedures govern use and removal of records and the conditions for release of information. A confidential clinical record containing pertinent past and current finding in accordance with accepted professional standards was maintained for every resident receiving assisting living services. Resident records, whether written or electronic, would be protected against loss, tampering or unauthorized disclosure in compliance with relevant federal and state laws. The facility would establish and implement procedures to control use, storage and security of the resident records and establish criteria for release of resident information. The facility may not disclose to any other person any personal, financial or medical information about the resident except: -as may be required by law -to employees or contractors of the facility another facility, other health care practitioner or provider or inpatient facility needing information to provide services to the resident, but only information necessary for the provision of services -to person authorized in writing by the resident, including third-party payer, and -to representatives of the commissioner authorized to survey or investigate facility's under this license or federal laws. In addition, following the resident's discharge or termination of services, an assisted living facility must retain a resident's record for at least five years or as otherwise required by state and federal regulations. Arrangement must be made for secure storage and retrieval of resident	02430			

Minnesota Department of Health

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02430	Continued From page 111 records if the facility ceases to operate. The Minnesota Bill of Rights for Assisted Living dated July 17, 2024, noted residents have the right to have personal, financial, health, and medical information kept private, to approve or refuse release of information to any outside party, and to be advised of the assisted living facility's policies and procedures regarding disclosure of the information. Resident's must be notified when personal records are requested by any outside party. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) day	02430			
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 signage was posted at the main entry of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all ten residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a	03090			

Minnesota Department of Health

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03090	Continued From page 112 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). Findings include: On September 3, 2024, at 10:46 a.m., the surveyor waited outside of the facility to gain entrance. The surveyor observed a darkened front door with a "no soliciting" sign adhered to the door. The surveyor did not observe an electronic monitoring sign. On September 3, 2024, at 2:06 p.m., during a tour of the facility with licensed assisted living director (LALD)-A, the surveyor did not observe a sign posted at the facility entrance regarding electronic monitoring. On September 3, 2024, at 3:17 p.m., LALD-A stated there were no electronic signs posted, "because I don't have any one here." LALD-A confirmed electronic monitoring information was not posted at the facility entrance as required. R1's Assisted Living contract signed by LALD-A on December 2, 2023, noted information about electronic monitoring was posted at each entrance accessible to visitors. The licensees' undated Electronic Monitoring policy noted effective January 1, 2020, facility complies with the Minnesota Electronic Monitoring law. No further information was provided.	03090			

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03090	Continued From page 113 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090			

Type: Full
Date: 09/04/24
Time: 11:37:00
Report: 1021241257

Food and Beverage Establishment Inspection Report

Page 1

Location:

Stanton House W Services Inc
3350 James Avenue N
Minneapolis, MN55412
Hennepin County, 27

Establishment Info:

ID #: 0038007
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6125219543
ID #:

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

The following orders were issued during this inspection.

2-200 Employee Health

2-201.11C

**** Priority 1 ****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

NO EMPLOYEE ILLNESS LOG ON-SITE. DISCUSSED EMPLOYEE ILLNESS POLICY AND RECORDING WITH LALD. AN MDH EMPLOYEE ILLNESS LOG SENT WITH REPORT.

Comply By: 09/04/24

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 FOOD THERMOMETER ON-SITE. PROVIDE A DIGITAL THIN PROBE FOOD THERMOMETER AS DESCRIBED IN RULE ABOVE.

Comply By: 09/11/24

4-300 Equipment Numbers and Capacities

4-302.13B

**** Priority 2 ****

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN DISH MACHINE. PROVIDE ONE THERMO LABEL LEFT ON-SITE.

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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 ON-SITE TO MEASURE THE CONCENTRATION OF SANITIZER. PROVIDE.

Comply By: 09/11/24

6-300 Physical Facility Numbers and Capacities

6-301.12 **** Priority 2 ****

MN Rule 4626.1445 Provide and maintain a supply of individual disposable towels, a continuous towel system, a heated-air hand drying device, or an approved ambient air temperature hand drying device at each handwashing sink or group of adjacent handwashing sinks.

NO PAPER TOWELS AT THE KITCHEN HANDWASHING SINK. PROVIDE AS DESCRIBED IN RULE ABOVE. MAINTAIN A SUPPLY OF PAPER TOWELS AT ALL HANDWASHING SINKS DURING ALL HOURS OF OPERATION.

Comply By: 09/11/24

2-100 Supervision

2-102.12AMN

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

NO CERTIFIED FOOD PROTECTION MANAGER (CFPM) EMPLOYED AT THIS ESTABLISHMENT. INFORMATION ON HOW TO OBTAIN CFPM SENT WITH REPORT.

Comply By: 10/07/24

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

NO THERMOMETER IN THE KITCHEN REFRIGERATOR. PROVIDE A THERMOMETER IN THE WARMEST PART OF THE REFRIGERATOR.

Comply By: 09/11/24

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

NO SANITIZER ON-SITE TO SANITIZE EQUIPMENT AND UTENSILS. SANITIZER FACT SHEET LEFT ON-SITE. PROVIDE A SANITIZER AS DESCRIBED IN RULE ABOVE.

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4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

THE FOLLOWING AREAS CONTAIN ACCUMULATION OF DUST, GREASE AND/OR OTHER DEBRIS: UNDER THE MICROWAVE, INSIDE KITCHEN DRAWERS, SHELVES IN KITCHEN CABINETS, INSIDE THE REFRIGERATOR. CLEAN AND MAINTAIN CLEAN.

Comply By: 09/11/24

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

HANDWASHING SINKS IN THE KITCHEN AND IN THE BATHROOMS ARE MISSING A HANDWASHING SIGN/POSTER THAT REMINDS FOOD EMPLOYEES TO WASH THEIR HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 09/11/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE EDGE OF THE LAMINATE COUNTERTOP IS DAMAGED. REPAIR LAMINATE COUNTERTOP SO IT IS SMOOTH, EASILY CLEANABLE AND DURABLE.

Comply By: 09/18/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

OBSERVED MICE DROPPINGS IN THE KITCHEN CABINETS AND DRAWERS. THERE IS NO FOOD IN ESTABLISHMENT. STAFF WILL CLEAN THE MICE DROPPINGS AND ROUTINELY INSPECT THE PREMISES. IF PROBLEMS PERSIST THEN CALL A PROFESSIONAL PEST CONTROL COMPANY.

Comply By: 09/11/24

Food and Equipment Temperatures

Process/Item: Ambient Temperature

Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR

Violation Issued: No

Type: Full
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Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	4	7

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH LALD, TERRA ROSS AND HEALTH REGULATION DIVISION NURSE EVALUATOR, CYNDI CASEY.

THIS FACILITY IS A RESIDENTIAL HOME AND THEY CURRENTLY HAVE 0 CLIENTS AND THE FACILITY CAN HAVE UP TO 5 CLIENTS.

SINCE FACILITY DOES NOT HAVE ANY CLIENTS, THERE IS NO FOOD ON-SITE.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, PAINTED DRYWALL, WOOD CABINETS, TEXTURED CEILING, LAMINATE COUNTERTOPS AND VINYL FLOORING. PHYSICAL FACILITY ITEMS WILL BE MONITORED DURING FUTURE INSPECTIONS.

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 1021241257 of 09/04/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

TERRA ROSS
LALD

Signed: _____

Melissa Ramos
Environmental Health Specialist
Metro District Office
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