



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 5, 2026

Licensee

Stanton House W Services Inc.

4847 Bryant Avenue North

Minneapolis, MN 55430

RE: Project Number(s) SL32730016

Dear Licensee:

On December 3, 2025, 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 4, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 4, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on September 4, 2025, found not corrected at the time of the December 3, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b-F) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on December 3, 2025 (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 \$500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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 Casey DeVries at 651-201-5917.

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,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/03/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	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: SL32730016-0 On November 25, 2025, through December 3, 2025, the Minnesota Department of Health conducted a license order follow up survey at the above provider, and the following correction orders are reissued. At the time of the survey, there were four residents, all of whom were 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.		
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving	{0 420}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 420}	Continued From page 1 housing or services provided by the facility. This MN Requirement is not met as evidenced by:	{0 420}	Not reviewed during this survey		
{0 450} SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by:	{0 450}			
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	{0 480}			

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

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{0 630}	Continued From page 4 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}	Not reviewed during this survey		
{0 650} SS=D	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	{0 650}			

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{0 650}	Continued From page 5 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey		
{0 660} SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. 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	{0 680}			

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{0 680}	Continued From page 6 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey		
{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,	{0 730}			

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{0 730}	Continued From page 7 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}	Not reviewed during this survey		

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{0 810}	Continued From page 10 review, the licensee failed to develop the fire safety and evacuation plan with the required content, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 28, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety & Evacuation Policy, undated, failed to include the following: The FSEP did not identify specific fire protection actions for residents. The section in the policy that addressed the responsibilities or basic evacuation procedures for residents indicated that residents should remain calm, follow staff instructions, not use elevators (which the facility did not have), and evacuate when instructed. There were no instructions for residents to follow indicating how to evacuate the building in the event of a fire or similar emergency. The FSEP failed to provide specific procedures	{0 810}			

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{0 810}	Continued From page 11 for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance. General procedures for residents with mobility impairments, cognitive impairments, and sensory impairments were included, however they were not specific to the residents living in the facility. Resident-specific procedures for assisting residents during evacuation must be included in the FSEP. On December 1, 2025, at 12:00 p.m., LALD-D stated they understood the parts of their policy that were still lacking relevant information and would work to bring them into compliance.	{0 810}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}		Not reviewed during this survey	

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{01060}	Continued From page 12	{01060}			
{01060} SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not	{01060}			

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{01060}	Continued From page 13 returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by:	{01060}	Not reviewed during this survey		
{01530} SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related	{01530}			

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{01530}	Continued From page 14 to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey		
{01560} SS=D	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De- (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation 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; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and	{01560}			

Minnesota Department of Health
STATE FORM 6899 LWRF12 If continuation sheet 16 of 19

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 12/03/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430		
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{01610}	Continued From page 16 This MN Requirement is not met as evidenced by:	{01610}	Not reviewed during this survey		
{01620} SS=F	144G.70 Subd. 2 (c-e) 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. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living	{01620}			

Minnesota Department of Health

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{01620}	Continued From page 17 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. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}	Not reviewed during this survey		
{01910} SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the	{01910}			

Minnesota Department of Health

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{01910}	Continued From page 18 medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey		
{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

Electronically Delivered

October 13, 2025

Licensee

Stanton House with Services Inc
4847 Bryant Avenue North
Minneapolis, MN 55430

RE: Project Number(s) SL32730016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on September 4, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$1,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

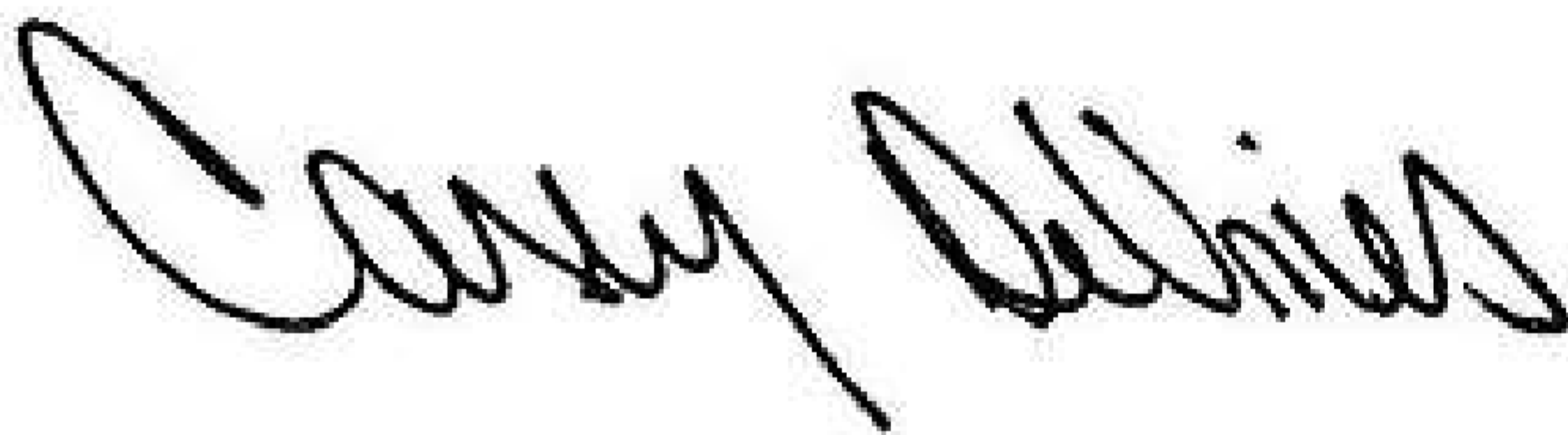
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" and last name "DeVries" clearly distinguishable.

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

AH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430		
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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: SL32730016-0 On September 2, 2025, through September 4, 2025, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents, all of whom were receiving services under the Assisted Living license. An immediate correction order was identified on September 3, 2025, issued for SL32730016-0, tag identification 1290. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged. An immediate correction order was identified on September 4, 2025, issued for SL32730016-0,	0 000	POC text Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 000	Continued From page 1 tag identification 2310. During the survey, the licensee took action to mitigate the immediate risk. However, noncompliance remained, and the scope and level remain unchanged.	0 000			
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the facility. 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 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:	0 420			

Minnesota Department of Health

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0 420	Continued From page 2 The licensee had an assisted living license, effective August 1, 2021. The most recent renewal effective date was April 18, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, 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 of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all 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." Page four was electronically signed by the owner on June 13, 2025. As a result of this survey, the following orders were issued under 0450, 0480, 0550, 0630, 0650, 0660, 0680, 0730, 0790, 0800, 0810, 0910, 1060, 1290, 1530, 1560, 1610, 1620, 1910, 2310, and 3090, which indicated the licensee's understanding of the Minnesota	0 420			

Minnesota Department of Health

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0 420	Continued From page 3 statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 450 SS=F	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure services were provided within the scope of practice of staff identified by the nurse practice act for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 450			

Minnesota Department of Health

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0 450	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-F was hired on November 14, 2016, to work as a lead ULP and also to provide direct cares and services to residents. On September 4, 2025, at 3:24 p.m., an immediate order for correction was issued to the licensee, tag identification number 2310. On September 4, 2025, at 6:54 p.m., via email correspondence, the licensee emailed the following documents for R1 related to the immediate order for correction: - Restraint: Side Rail Utilization Assessment, signed by ULP-F and dated July 11, 2024; - Resident Bed Rail Consent Form, signed by ULP-F and dated July 11, 2024; - Side Rail Use Assessment Form, signed by ULP-F and dated July 11, 2024; and - Bed Rail Assessment in Compliance with FDA Standards, signed by ULP-F and dated July 11, 2024. On September 4, 2025, at 6:56 p.m., via email correspondence, ULP-F emailed a response regarding bed rail assessments which read, "All 3 residents had an initial bed rail assessment in their charts. Our current nurse did not do these so she did not know to put the actual measurements in her 90 day assessments. I have updated our rtasks to include the measurements in the 90 day assessment." On September 5, 2025, at 9:29 a.m., via email correspondence, the surveyor's supervisor	0 450			

Minnesota Department of Health

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0 450	Continued From page 5 inquired the following: "The documents you provided for [R1] are all signed by [ULP-F] who is identified on the documents as "agency lead" and who is an unlicensed personnel. Why is a ULP working outside of their scope of practice to conduct nursing assessments? " 144G.70 SERVICES. (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. " 144G.41 Subdivision 1. (1-4) Minimum requirements. (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285. " 148.171 DEFINITIONS; TITLE. Subd. 20.Registered nurse. "Registered nurse," abbreviated RN, means an individual licensed by the board to practice professional nursing." On September 5, 2025, at 10:36 a.m., via email correspondence, the licensee replied to the above inquiry and indicated, "We were told in a previous survey that she [referring to ULP-F] could do the bed rail assessment. As it was not a nursing assessment. [ULP-F] does not do nursing assessments." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 450			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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0 480	Continued From page 6 (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; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 480	Continued From page 7 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: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated September 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 8	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 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 and reporting contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD), and Minnesota Adult Abuse Reporting Center (MAARC). 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	0 550			

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0 550	Continued From page 9 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 2, 2025, at 12:04 p.m., during the facility tour, the surveyor observed contact information for the Office of Ombudsman for Long Term Care (OOLTC), and Office of Health Facility Complaints (OHFC) posted on a bulletin board in the dining room. The surveyor observed the licensee lacked the following postings: - MAARC; and - OMHDD. On September 2, 2025, at 1:23 p.m., licensed assisted living director (LALD)-D stated they were aware of the requirement to post the above listed contact information. LALD-D stated they did not know what happened to the postings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 630 SS=E	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	0 630			

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0 630	Continued From page 10 person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted to the licensee on July 11, 2024, with diagnoses that included multiple sclerosis, altered mental status, neurocognitive disorder, and unspecified psychosis. R1's unsigned Service Plan with effective date of July 4, 2025, indicated R1 received services for bathing, dressing, grooming, incontinence care, medication administration, meal assistance, and home safety check.	0 630			

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0 630	Continued From page 11 R1's IAPP completed on August 11, 2025, indicated R1 was not at risk to be abused. R1's IAPP did not contain an individualized review or assessment of R1's risk of abusing other vulnerable adults. R3 R3 was admitted to the licensee on October 4, 2020, with diagnosis that included hyperlipidemia, chronic obstructive pulmonary disease, eating disorder, essential hypertension, morbid obesity, schizoaffective disorder, type 2 diabetes mellitus without complications, congestive heart failure. R3's unsigned Service Plan with effective date of August 11, 2025, indicated R3 received services for bathing, ambulation, dressing, grooming, toileting, medication administration, meal assistance, and home safety check. R3's IAPP completed on September 2, 2025, indicated R3 was not at risk to be abused. R3's IAPP did not contain an individualized review or assessment of R3's risk of abusing other vulnerable adults. On September 4, 2025, at 11: 50 a.m., via telephone, clinical nurse supervisor (CNS)-C stated the missing content for the above two residents was an oversight, and they would take it as an educational moment. The licensee's undated Abuse Prevention Plan policy, indicated all residents admitted to the facility will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other	0 630			

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0 630	Continued From page 12 vulnerable adults. The facility will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse. The plan will be incorporated into the resident's care plan and will reflect their ability to participate in and direct their own care in the presence of an identified caregiver. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=D	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	0 650			

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0 650	Continued From page 13 (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included all required content for one of three employees (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-H was hired on September 12, 2024, to provide direct care services to residents. ULP-H's employee record included TB Screening and TB Risk Assessment completed on September 11, 2024. ULP-H's employee record lacked evidence a TST or other evidence of TB screening such as a blood test, was completed upon hire or within 90 days prior to hire. On September 4, 2025, at 12:03 p.m., clinical nurse supervisor (CNS)-C stated the lead ULP (ULP-F) handled TB screening for new employees. CNS-C stated TB screening was not	0 650			

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0 650	Continued From page 14 their responsibility. CNS-C stated they were not aware ULP-H was missing TST or other evidence of TB screening such as a blood test. On September 4, 2025, at 3:44 p.m., LALD-D stated ULP-F was responsible for employee records. On September 4, 2025, at 3:48 p.m., ULP-F stated they could not find ULP-H's TB screening result and stated they were looking for it. ULP-F stated they had placed a call to ULP-H and ULP-H did not get back to them. ULP-F stated the previous surveyors might have misplaced ULP-H's document and stated they would have to look for it. On September 9, 2025, at 12:35 p.m., via email correspondence post-survey, licensed assisted living director (LALD)-D provided the surveyor with ULP-H's Lab Report QuantiFERON TB Gold plus dated September 10, 2024. The email did not indicate why the document was not available during the survey. The licensee's undated Personnel Records policy read, "1. PERSONNEL RECORDS: a. The personnel record for an employee shall include, but not be limited to, the following: 1) Evidence of current professional licensure, registration, or certification 2) Records of orientation to the facility, the license, and employee roles and responsibilities 3) Records of annual training including infection control training and competency evaluations 4) Health screening (as required under 144A.4798) for those providing resident services and the dates of screening and results (Mantoux, chest X-ray reports)	0 650			

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0 650	Continued From page 15 5) A current job description that includes qualifications, responsibilities, and the level of staff providing supervision. Job descriptions must be signed by the employee. 6) Annual performance evaluation that identifies areas of improvement needed and training needs 7) Documentation of background study as required by MN Statute 144.057" No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the	0 660			

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0 660	Continued From page 16 most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included a two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test, for one of three employees (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on January 9, 2025, to provide direct care services to residents. ULP-B's employee record included TB Screening and TB Risk Assessment completed on January 14, 2025, five days after ULP-B's hire date. ULP-B's employee record included a negative TST Report read on May 2, 2025, for the first step TST, administered on April 30, 2025, ULP-B's record lacked evidence a second step TST was done. ULP-B's employee record included after visit summary (AVS) dated May 23, 2025, which indicated ULP-B was seen at urgent care for acute cough, exposure to TB and smoker. The AVS indicated a negative QuantiFERON TB Gold plus result and a referral for chest X ray. ULP-B's employee record did not include the chest X ray result. ULP-B's employee record lacked a second step TST result or other evidence of TB screening such as a blood test,	0 660			

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0 660	Continued From page 17 was completed upon hire or 90 days prior to hire. On September 8, 2025, at 10:54 a.m., following the survey, via email correspondence, licensed assisted living director (LALD)-D provided the surveyor with ULP-B's negative chest x ray result dated May 23, 2025. On September 4, 2025, at 12:03 p.m., clinical nurse supervisor (CNS)-C stated the lead ULP (ULP-F) handled TB screening for new employees, CNS-C stated TB screening was not their responsibility. CNS-C stated they used to do TST for TB screening, but employees did not go for the second TST, so the licensee switched it to QuantiFERON TB Gold plus instead of TST. CNS-C stated they did not know why the TB screening was completed late for ULP-B. Although the licensee was able to demonstrate ULP-B received a QuantiFERON TB Gold plus test and correlating chest X ray, they were only completed when ULP-B presented to urgent care with acute cough and exposure to TB, 134 days after ULP-B's hire date. Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, indicated baseline TB screening is required for all health care workers. Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease, 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test (IGRA).	0 660			

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0 660	Continued From page 18 An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. The Licensee's undated Tuberculosis Screening Policy, read, " 1. The health screening will be completed by a licensed professional before resident contact. Health screening will occur after a conditional offer of employment is made. Repeat testing will be required if deemed necessary by the health care professional for individuals with signs of communicable disease. The nurse manager/designee will be responsible for assuring testing is completed and for any necessary follow-up. This will include any necessary training of supervisors and employees. 2. For all employees, volunteers or contract personnel providing direct resident care, there shall be evidence of baseline TB screening consisting of two components: a. Assessing for current symptoms of active TB disease, (see Baseline TB Screening Tool in Sample Forms) and b. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or a single TB blood test. If the employee has proof of a TB blood test or negative Chest X-ray within 90 days of employment, it does not have to be repeated at the time of hire. c. Employee history of BCG vaccination should be disregarded when administering and interpreting TST results 3. Tuberculin Skin Test (TST)	0 660			

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0 660	Continued From page 19 a. TST is an intradermal injection of 0.1 ml of tuberculin (PPD) on the inner surface of the forearm. The test is an intradermal injection and should produce a pale elevation of the skin (a wheal) 6-10 mm in diameter. The skin test reaction should be read between 48-72 hours after administration. If the test is not read within 72 hours, another TST should be placed unless the amount of induration is 10mm or greater within 7 days. b. The reaction should be measured in millimeters of induration (palpable, raised, hardened area or swelling). Do not measure erythema (redness). The indurated area should be measured across the forearm (perpendicular to the long axis.) Health care workers, residents, or their family members may not record their own results. c. Determination for a positive TST result depends on the individual's risk factors for TB exposure or for developing active TB disease if infected. d. People who have been vaccinated with BCG should not be exempted from TB skin testing unless they have a documented positive result from a prior test. e. Employees with positive TST results must receive appropriate medical follow-up. 4. Two step testing a. A two step TST is required for baseline TB screening of health care workers who have not had a TST (Mantoux) within the previous three (3) months of hire. If employee received Mantoux within 3 months of employment, that will be considered Step 1. Step 2 placed at time of hire. b. A two step Mantoux is performed at baseline because people who were infected with TB many years ago may have a negative reaction to an initial TST. The first "step" may stimulate the	0 660			

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0 660	Continued From page 20 immune system's ability to react to the test. If the second "step" is not performed as part of baseline screening, a subsequent positive reaction could be misinterpreted as a new infection. If the first test is positive, second step is not given and employee would be referred for chest x-ray. c. If the first test is negative and the second step is positive, that indicates a boosted response and no further testing is necessary. (see attached Two Step Testing guidelines.) d. Treatment is encouraged for all health care personnel with untreated L TBI (latent TB infection), unless medically contraindicated." 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	0 680			

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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
0 680	Continued From page 21 disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's EPP last updated June 1, 2022, lacked evidence of the following required content: - quarterly review of missing residents policy; - yearly review of the EPP; - hazard vulnerability assessment tool was left blank; - subsistence needs for staff and residents including emergency lighting; - procedure for tracking of staff and patient;	0 680			

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0 680	Continued From page 22 - policies and procedures for volunteers; - arrangements with other facilities; and - subsistence needs for staff and residents including emergency lighting. On September 4, 2025, at 2:36 p.m., licensed assisted living director (LALD)-D stated the missing resident plan and the EPP was reviewed once a year. LALD-D stated they did not have documentation to demonstrate the review was done yearly. On September 4, 2025, at 3:11 p.m., LALD-D stated they were not aware the EPP was missing the above listed items. The licensee's Missing Resident policy dated May 5, 2022, indicated the missing resident procedure will be reviewed by the Director and Clinical Nurse Supervisor at least quarterly. The licensee's Emergency Management Policy dated May 5, 2022, indicated the licensee will have an identified plan in place to ensure the safety and well-being of residents and employees during periods of an emergency or a disaster that disrupts facility services. The emergency preparedness plan/program will be reviewed/updated at least annually. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730			

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0 730	Continued From page 23 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to 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;	0 730			

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0 730	Continued From page 24 (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 provide a discharge summary with required content for one of one resident (R5) discharged from the licensee. 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: R5 was admitted to the licensee on October 1, 2019, and discharged from the licensee on July 28, 2025. R5's progress notes written on January 31, 2024, by clinical nurse supervisor (CNS)-C indicated R5 was sent to the emergency room due to redness and warmth to the left foot for suspected infection of the left foot. R5's progress notes dated July 28, 2025, written by CNS-C indicated R5's family decided to transfer R5 to a different facility due to	0 730			

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0 730	Continued From page 25 non-weight bearing status and family picked up R5's belongings. R5's Discharge-Transfer Summary printed on September 4, 2025, contained R5's diagnosis, allergies, service initiation, a support network, finance/ care decisions, and vaccination status. R5's discharge summary lacked the following required information: -a summary of the resident's stay that included courses of illnesses, treatments and therapies, and pertinent lab, radiology, and consultation results; -a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that includes the resident status, including baseline and current mental, behavioral, and functional status; -a reconciliation of all predischage medications with the resident's post discharge prescribed and over-the-counter medications; and -a post discharge plan that is developed with the resident and, with the resident's consent, the resident's representatives, which will help the resident adjust to a new living environment. The post discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post discharge medical and nonmedical services the resident will need. On September 4, 2025, CNS-C stated they did not do the Discharge/ Transfer Summary for R5. CNS-C stated they only wrote the progress note mentioned above. CNS-C stated they did not have access to the Discharge /Transfer Summary form on ResiDex (electronic medical record software). CNS-C stated they had no knowledge	0 730			

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0 730	Continued From page 26 of the above mentioned Discharged/Transfer Summary form for R5. The Licensee's undated Resident Discharge Process policy read, "Discharge Summary 1. A discharge summary will be prepared at the time of discharge. 2. The facility will provide the resident/representative with a written discharge summary at time of discharge. 3. Copies of the discharge summary will be provided to other disciplines as required or as approved by the resident. 4. The discharge summary will include: a. Diagnoses b. Courses of illness c. Allergies d. Treatments/therapies e. Pertinent lab results f. Pertinent X-ray results g. Pertinent consultation results h. Summary of resident status based on latest assessment i. Resident status at baseline or when admitted ii. Current mental, behavioral and functional status i. Reconciliation of all predischage medications with post discharge prescribed and over the counter medications J. Post discharge plan developed with the resident and with consent the resident's representatives k. The plan will include: i. Planned residence ii. Arrangements with follow-up care iii. Needed medical and non-medical services after discharge 5. The discharge summary may be developed	0 730			

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0 730	Continued From page 27 by the RN, Assisted Living Director or designee appropriate to information required in the discharge summary based on the resident and the services they received during the facility stay. 6. A copy of the discharge summary is filed in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 790 SS=C	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 had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when	0 790			

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0 790	Continued From page 28 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, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-A. The portable fire extinguishers throughout the facility were not installed on hangers or brackets. The portable fire extinguisher in the dining room was sitting on the window sill. Hand-held portable fire extinguishers, not housed in cabinets, shall be installed on the hangers or brackets supplied. Hangers or brackets shall be securely anchored to the mounting surface in accordance with the manufacturer ' s installation instructions. This deficient condition was visually verified at the time of discovery by ULP-A accompanying on the tour. 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 29 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, in a continuous state of good repair and operation. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On September 3, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-A. The following was observed: Resident Bathroom 2 - The double gang (two switch levers) light switch was damaged where one of the switch levers was broken and the other switch lever was broken and pushed inside the electrical box. - The wood base by the shower was warped/damaged and pulling away from the wall. A piece of the wood base board in the same area was removed from the wall and exposed the drywall and structure to the wet environment adjacent to the shower.	0 800			

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0 800	Continued From page 30 Hallway - The walls, trim, and doors were all damaged in the hallway. There were multiple locations where the interior structure of the wall was exposed. - The floor outside bathroom 3 had water damage and could be a possible trip hazard. The laminate plank flooring was warped and some of the top material was coming off of the floor creating an uneven walking surface. Bedroom 3 - The laminate plank flooring inside bedroom 3 was damaged and could be a possible trip hazard. The surface was warped and peeling in multiple areas. Some of the floor boards had areas where the top material was damaged exposing the inner plank material creating an uneven walking surface. Bedroom 4 - The laminate plank flooring inside bedroom 4 was damaged and could be a possible trip hazard. The joints in the flooring material were pulled apart from each other and exposed the underlayment below. The surface was warped and peeling in multiple areas. Bedroom 5 - The door jamb was damaged adjacent to the strike plate (metal plate affixed to a doorjamb that holds the door closed) with nail heads protruding into the clear door opening. These deficient conditions were visually verified at the time of discovery by ULP-A accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7)	0 800			

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0 800	Continued From page 31	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff 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) Staff 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 staff 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.	0 810			

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0 810	Continued From page 32 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, to provide the required training, and to conduct evacuation drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 3, 2025, from 10:00 a.m. to 11:00 a.m., the surveyor toured the facility with unlicensed personnel (ULP)-A. The evacuation plan diagrams identified the door to the garage as part of the exit path. Egress shall not pass through kitchens, storage rooms, closets or spaces used for similar purposes. The swinging door inside the garage was obstructed by multiple, miscellaneous items stored in front of it. The path to the door was obstructed by a vehicle parked in the garage. On September 3, 2025, licensed assisted living director (LALD)-D provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.	0 810			

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0 810	Continued From page 33 FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, Fire Safety, dated May 5, 2022, failed to include the following: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance, any resident-specific procedures to staff for assisting residents during evacuation, nor did it include instructions for staff to follow in case of relocation. On September 3, 2025, at 1:30 p.m., unlicensed personnel (ULP)-A stated they memorized all the individual evacuation needs for each resident and it was not written down anywhere, but all the staff knew the residents well enough to know how to evacuate them. The policy reviewed was an unedited policy from a third-party provider that was not specific to the facility, staffing model, or residents.	0 810			

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0 810	Continued From page 34 TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-D lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-D lacked documentation showing any training was completed or training was scheduled for a future date for employees on the fire safety and evacuation plan. On September 3, 2025, at 1:30 p.m., LALD-D stated they do training at staff meetings and keep the documentation off site. The surveyor requested documentation be emailed to them by end of day on September 3, 2025. No email or documentation was received. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and	0 910			

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0 910	Continued From page 35 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for all residents who resided in the licensee's 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 the potential to affect a large portion or all the residents). The findings include: On September 4, 2025, at 3:15 p.m., licensed assisted living director (LALD)-D provided a blank contract titled Assisted Living Contract. On September 4, 2025, at 3:14 p.m., LALD-D stated the blank contract was used for all residents who resided in the assisted living. The licensee's Assisted Living Contract lacked the following required content: - in a conspicuous place and manner on the contract the Health Facility Identification number (HFID#) of the facility. On September 4, 2025, at 3:17 p.m., LALD-D stated they were not aware the HFID# was missing from the contract. No further information was provided.	0 910			

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0 910	Continued From page 36	0 910			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case	01060			

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01060	Continued From page 37 manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Discharge or Deceased Resident Roster dated July 1, 2025, indicated R5 was admitted to the licensee on October 1, 2019, and discharged from the licensee on July 28, 2025. R5's diagnosis included schizophrenia, obsessive compulsory diseases, and type 2 diabetes mellitus. R5's service recap summary for the month of June 2023, indicated R5 received assistance with	01060			

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01060	Continued From page 38 bathing reminder, dressing, toileting, glasses care, symptom management, behavior management, medication administration, meals reminder, and safety check. R5's progress notes written on January 31, 2024, by clinical nurse supervisor (CNS)-C indicated R5 was sent to the emergency room due to redness and warmth to the left foot for suspected infection of the left foot. R5's progress notes dated July 28, 2025, written by CNS-C indicated R5's family decided to transfer R5 to a different facility due to non-weight bearing status and family picked up R5's belongings. R5's Discharge-Transfer Summary printed on September 4, 2025, indicated R5 was discharged to a nursing home on July 28, 2025. R5's record lacked evidence a written notice was provided to relevant parties that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident	01060			

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01060	Continued From page 39 may submit an appeal; and - a notice to the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. On September 4, 2025, at 12:34 p.m., CNS-C stated they did not provide the emergency relocation form to R5. CNS-C also stated they had not notified the Office of Ombudsman about R5's relocation. CNS-C stated they were not aware of the requirement to provide a written notice with required contents for an emergency relocation or the requirement to notify the Office of Ombudsman if the resident stayed out of the facility for more than four days. The licensee's Exhibit 11, Discharge and Transfer of Residents policy dated May 2, 2022, and included in the assisted living contract read, "25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to the facility within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			

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01290	Continued From page 40	01290			
01290 SS=H	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study (BGS) was submitted and received in affiliation with the assisted living licensee for three of 16 employees (unlicensed personnel (ULP)-E, ULP-G, ULP-F). This had the potential to affect all residents living in the assisted living facility. This resulted in an immediate correction order on September 3, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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,	01290			

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01290	Continued From page 41 or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-E ULP-E was hired on February 21, 2022, to provide direct cares and services to residents. The licensee's employee schedule from September 1, 2025, through September 7, 2025, indicated ULP-E was scheduled to work mid shift (12:00 p.m. to 4:00 p.m.,) on September 6, and 7. The licensee's NETStudy 2.0 (web-based system used to submit background study requests to the Department of Human Services (DHS)) roster did not include ULP-E in the list of employees whose BGS were affiliated to the licensee's healthcare facility identification (HFID) 32730. A screenshot taken from the DHS website on September 3, 2025, at 11:37 a.m., indicated ULP-E was separated from the licensee's HFID 32730 on February 7, 2023. A screenshot taken from the DHS website on September 3, 2025, at 11:40 a.m., indicated ULP-E was included on the roster for the licensee's sister facility HFID 25977, but indicated ULP-E's eligible COVID-19 Study expired on December 31, 2022. ULP-G ULP-G was hired on July 7, 2025, to provide direct cares and services to residents. The licensee's Employee schedule from September 1, 2025, through September 7, 2025,	01290			

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01290	Continued From page 42 indicated ULP-G was scheduled to work morning shift (7:00 a.m. to 3:00 p.m.) on September 6, 2025. The licensee's NETStudy 2.0 roster did not include ULP-G in the list of employees whose BGS were affiliated to the licensee's HFID 32730. A screenshot taken from the DHS website on September 3, 2025, at 11:55a.m., indicated ULP-G was separated from the licensee's HFID 32730 on July 2, 2025. The screenshot also indicated ULP-G was affiliated to the licensee's sister facility HFID 25977 on September 2, 2025, during the survey and that supervision was required for ULP-G. An additional screenshot from the DHS website on September 3, 2025, at 11:55 a.m., indicated ULP-G was separated from the roster for HFID 32730 due ULP-G not having been fingerprinted within the required time frame. ULP-F ULP-F was hired on November 14, 2016, to work as a lead ULP and to provide direct cares and services to residents. The licensee's Employee schedule from September 1, 2025, through September 7, 2025, did not include ULP-F. The licensee's NETStudy 2.0 roster did not include ULP-F in the list of employees whose BGS were affiliated to the licensee's HFID 32730. A screenshot taken from the DHS website on September 3, 2025, at 11:49 a.m., indicated ULP-F was affiliated to the licensee's sister facility HFID 25977 on January 23, 2023.	01290			

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01290	Continued From page 43 A screenshot taken from the DHS website on September 3, 2025, at 11:50 a.m., indicated ULP-F was separated from the licensee's HFID 32730 on February 8, 2023. On September 3, 2025, at 12:59 p.m., licensed assisted living director (LALD)-D stated ULP-F was a lead worker; ULP-F did employee training and hiring. LALD-D also stated ULP-F took residents to their appointments unsupervised. On September 3, 2025, at 1:00 p.m., LALD-D stated ULP-E worked with residents unsupervised. LALD-D stated ULP-G was supervised by the lead worker ULP-F. On September 3, 2025, at 1:30 p.m., LALD-D stated ULP-F helped ULP-G with medication pass and time management. LALD-D stated, " I think" ULP-G had to be at the facility all the time when ULP-F worked. On September 3, 2025, at 1:33 p.m., LALD-D stated they were not aware ULP-E's COVID-19 eligibility status was expired. On September 3, 2025, at 1:34 p.m., LALD-D stated they were aware ULP-G did not have a BGS clearance and that was why ULP-F was supervising ULP-G. On September 3, 2025, at 1:36 p.m., LALD-D stated, "[ULP-F] need to be affiliated, it might be typo." On September 3, 2025, at 2:10 p.m., via telephone, ULP-E stated they did work with residents unsupervised.	01290			

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01290	Continued From page 44 On September 3, 2025, at 2:25 p.m., ULP-F stated they could not affiliate their BGS to the licensee's HFID because they had a set aside disqualification status. ULP-E had Covid-19 study, and they were unable to affiliate ULP-G to the licensee's HFID. ULP-F stated they did not know what eligibility- Covid -19 study expired meant, ULP-G's does not say eligibility- Covid -19 study expired it just says covid study. The licensee's undated Background Studies Policy indicated employees may not work until the results of the background study have been received. The law allows an individual to provide direct contact services while a study is pending if that person is under continuous direct supervision of the employer. On September 3, 2025, the Minnesota Department of Human Services website indicated the following: - Emergency studies completed during the COVID-19 pandemic were no longer valid. - Individuals who only had an emergency study must have a fully compliant, fingerprint-based background study. Roster maintenance - Individuals with a completed emergency study will remain on the entity's roster unless the entity removes the individual. Entities should remove individuals with emergency studies that are no longer affiliated; - If the individual should no longer be affiliated and has a new fully compliant background study, the entity should wait until the individual is separated and then remove both the emergency study and fully compliant study from their roster at the same time; - All entities are responsible for maintaining their	01290			

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01290	Continued From page 45 rosters regularly and removing study subjects from their roster when they are no longer affiliated; and - Entities are responsible for identifying who needs to submit a new background study. For help identifying which study subjects still have an emergency study and need a fully compliant study, entities should refer to the instructional guide, "Identifying Emergency Studies" in the help section of NETStudy 2.0. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01530 SS=D	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160	01530			

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01530	Continued From page 46 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation 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 staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation 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 (unlicensed personnel (ULP-H) received at least eight hours of initial dementia care training within 160 working hours of their employment start date. 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).	01530			

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01530	Continued From page 47 The findings include: ULP-H was hired on September 12, 2024, to provide direct care services to residents. ULP-H's employee record lacked evidence to demonstrate ULP-H had received the required eight hours of initial dementia training. On September 4, 2025, at 1:09 p.m., clinical nurse supervisor (CNS)-C stated they did not know why ULP-H did not have the required eight hours of dementia training. CNS-C stated the lead ULP (ULP-F) did the training for all employees. On September 4, 2025, at approximately 1:30 p.m., licensed assisted living director (LALD)-D stated they thought ULP-H had worked over 160 hours. On September 4, 2025, at 3:02p.m., via email correspondence, the surveyor received ULP-H's certificate of completion for four hours of Continuing Education in Caring for Clients with Dementia. ULP-H's dementia training record was four hours short of the required eight hours of dementia training. On September 4, 2025, at 3:44 p.m., LALD-D stated ULP-F was responsible for employee records. On September 4, 2025, 3:47 p.m., ULP-F did not answer when asked why ULP-H did not have the required eight hours of dementia training. On September 4, 2025, at 3:55 p.m., the	01530			

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01530	Continued From page 48 surveyor inquired with LALD-D if they had checked to see the exact number of hours ULP-H had worked for the licensee. LALD-D stated they were not sure how many hours the ULP had worked. The surveyor requested LALD-D provide supporting documents via email if the ULP had worked less than 160 hours. The surveyor did not receive additional information regarding the number of hours worked by ULP-H. The licensee's undated Dementia Care Training policy indicated direct care employees must have completed at least eight hours of initial training on required topics in the 160 hours from employment. Until this training is complete, the employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements or a supervisor meeting the requirements must be available for consultation with the new employee until the training requirement is complete. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01560 SS=D	144G.64 (a; 5), (b) Training in Dementia, Mental Illness, and De- (5) new staff members may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required dementia, mental illness, and de-escalation training include:	01560			

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01560	Continued From page 49 (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; (5) person-centered planning and service delivery; (6) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (7) de-escalation techniques and communication; and (8) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide dementia care training on the required topics for one of two 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 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).	01560			

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01560	Continued From page 50 The findings include: ULP-B was hired on January 9, 2025, to provide direct care services to residents. On September 5, 2024, at 4:00 p.m., the surveyor observed ULP-B completing tasks in the living room. ULP-B's employee record included Certificate of Completion for four hours of Continuing Education in Caring for Clients with Dementia dated January 25, 2025, which included the following topics: - o An Overview of the Causes - o Progression and Triggers - o Effective Interventions - o Effective Interventions in ADL's - o Interventions for Losses in Brain Function - o Working with Families of Clients with Dementia ULP-B's employee record included an acknowledgment form completed on January 14, 2025, which indicated ULP-B had completed person centered care practices training. On September 4, 2025, at 1:09 p.m., clinical nurse supervisor (CNS)-C stated they did not know why ULP-B did not have the required eight hours of dementia training. CNS-C stated the lead ULP (ULP-F) did the training for all employees. On September 4, 2025, at approximately 1:30 p.m., licensed assisted living director (LALD)-D stated they thought ULP-B had worked over 160 hours.	01560			

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01560	Continued From page 51 On September 4, 2025, at 3:02 p.m., via email correspondence, the surveyor received ULP-B's Certificate of Completion for four hours of Continuing Education in Caring for Clients with Dementia completed on January 12, 2025, with the same training contents as the dementia training completed on January 25, 2025. ULP-B's record lacked the following required topic of dementia training: (1) an explanation of Alzheimer's disease and other dementias; (2) problem solving with challenging behaviors; (3) communication skills; (4) recognizing symptoms of common mental illness diagnoses, including but not limited to mood disorders, anxiety disorders, trauma- and stressor-related disorders, personality and psychotic disorders, substance use disorder, and substance misuse; (5) de-escalation techniques and communication; and (6) crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. On September 4, 2025, at 3:44 p.m., LALD-D stated ULP-F was responsible for employee records. On September 4, 2025, 3:47 p.m., ULP-F stated they sent 4 hours of additional training certificate for ULP-H. ULP-F stated the contents for the dementia training completed on January 12, 2025, and January 25, 2025, were the same because the employees received the contents on two separate instances.	01560			

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01560	Continued From page 52 The licensee's undated Dementia Care Training policy, indicated required dementia training topics included: - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	01610			

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01610	Continued From page 53 by: Based on interview and record review, the licensee failed to conduct a nursing assessment by a registered nurse (RN) of the physical and cognitive needs prior to the date on which a prospective resident executed a contract with a facility or the date on which a prospective resident moved in, whichever was earlier, for two of two residents (R1, R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on July 11, 2024, with diagnoses that included multiple sclerosis, altered mental status, neurocognitive disorder, and unspecified psychosis. R1's unsigned Service Plan with effective date of July 4, 2025, indicated R1 received services for bathing, dressing, grooming, incontinence care, medication administration, meal assistance, and home safety check. R1's record included nursing admission assessment completed on July 22, 2024, 11 days post R1's admission date. R2	01610			

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01610	Continued From page 54 R2 was admitted to the licensee on September 11, 2024. R2's diagnoses included hyperkalemia, acute renal failure on dialysis, acute renal failure, unspecified acute renal failure type, chronic back pain, diabetic ketoacidosis with coma associated with other specified diabetes mellitus, hypovolemic shock, hyperosmolar hyperglycemic state hypertension, lactic acidosis, other specified diabetes mellitus without complication with long term current use of insulin. R2's Service Plan dated June 6, 2025, indicated R2 received services for activities, laundry, meal reminder, medication administration, safety checks, and symptom screening. R2's record included admission assessment completed on September 16, 2024, five days post R2's admission date. On September 2, 2025, at approximately 11:00 a.m., during the entrance conference clinical nurse supervisor (CNS)-C stated their admission process was that they complete admission assessments within five days of admission, followed by a seven-day assessment, 14-day assessment, 30-day assessment, 90-day assessment, and change of condition assessment. On September 4, 2025, at 12:21 p.m., CNS-C stated the admission process guideline mentioned above, for completing admission assessment within five days of admission was posted in their office and that was what they were following to complete assessments, however CNS-C stated they did not complete any of the admissions for the licensee's residents. CNS-C stated the previous nurse completed the	01610			

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01610	Continued From page 55 admission assessments. The licensee's undated Nursing Assessment and Reassessment of Residents policy indicated the facility will conduct a nursing assessment prior to the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier. The assessment will be done by a registered nurse and will assess the physical and cognitive needs of the prospective resident and propose a temporary service plan. If necessary, this assessment may be completed using telecommunication methods based on practice standards that meet the resident's needs and reflect person centered planning and care delivery. No further 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 (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	01620			

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01620	Continued From page 56 conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01620			

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01620	Continued From page 57 licensee failed to ensure the registered nurse (RN) conducted ongoing resident assessment and reassessment, not to exceed 90 calendar days from the last date of the assessment for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted to the licensee on July 11, 2024, with diagnoses that included multiple sclerosis, altered mental status, neurocognitive disorder, and unspecified psychosis. R1's unsigned Service Plan with effective date of July 4, 2025, indicated R1 received services for bathing, dressing, grooming, incontinence care, medication administration, meal assistance, and home safety check. R1's record included nursing admission assessment completed on July 22, 2024, 11 days post R1's admission date. R1's record included 90-day nursing assessments dated February 26, 2025, and May 28, 2025. The assessment completed on May 28, 2025, was 1 day past the 90-calendar day requirement.	01620			

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01620	Continued From page 58 R2 R2 was admitted to the licensee on September 11, 2024. R2's diagnoses included hyperkalemia, acute renal failure on dialysis, acute renal failure, unspecified acute renal failure type, chronic back pain, diabetic ketoacidosis with coma associated with other specified diabetes mellitus, hypovolemic shock, hyperosmolar hyperglycemic state hypertension, lactic acidosis, other specified diabetes mellitus without complication with long term current use of insulin. R2's Service Plan dated June 6, 2025, indicated R2 received services for activities, laundry, meal reminder, medication administration, safety checks, and symptom screening. R2's record included 90-day nursing assessments dated January 27, 2025, May 5, 2025, and September 3, 2025, (during the survey). The May 5, 2025, assessment was 8 days past the 90-calendar day requirement. The September 3, 2025, assessment was 31 days past the 90-calendar day requirement. R3 R3 was admitted to the licensee on October 4, 2020, with diagnosis that included hyperlipidemia, chronic obstructive pulmonary disease, eating disorder, essential hypertension, morbid obesity, schizoaffective disorder, type two diabetes mellitus without complications, and congestive heart failure. R3's unsigned Service Plan with effective date of August 11, 2025, indicated R3 received services for bathing, ambulation, dressing, grooming, toileting, medication administration, meal	01620			

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01620	Continued From page 59 assistance, and home safety check. R3's record included 90-day nursing assessments dated January 27, 2025, May 5, 2025, and September 2, 2025, (during the survey). The May 5, 2025, assessment was 8 days past the 90-calendar day requirement. The September 2, 2025, assessment was 30 days past the 90-calendar day requirement. On September 4, 2025, at 12:21 p.m., clinical nurse supervisor (CNS)-C stated, 90-day assessments were completed late because they were still learning the process and the system did not alert the CNS to complete the 90-day assessments. The licensee's undated Nursing assessment and Reassessment of Residents policy indicated resident reassessment, and monitoring must be conducted no more than 14 calendar days after initiating services. On-going reassessment and monitoring will be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a	01910			

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01910	Continued From page 60 resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation of disposition of medications for one of one discharged resident (R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Discharge or Deceased Resident Roster dated July 1, 2025, indicated R5 was admitted to the licensee on October 1, 2019, and	01910			

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01910	Continued From page 61 discharged from the licensee on July 28, 2025. R5's diagnosis included schizophrenia, obsessive compulsory diseases and type 2 diabetes mellitus. R5's service recap summary for the month of June 2023, indicated R5 received assistance with bathing reminder, dressing, toileting, glasses care, symptom management, behavior management, medication administration, meals reminder, and safety check. R5's medication administration record dated for the month of June 2025, indicated R5 took the following medications: omeprazole 20 milligram (mg) tablet (tab), aspirin 81mg tab, fluticasone nasal spray, hydrochlorothiazide 25mg, hydrocortisone cream, Janumet 50-1000mg, lisinopril 10mg, loratadine 10mg, tamsulosin hydrochloride, triamcinolone cream, vitamin D3 2,000unit tab, dimethicone petroleum, atorvastatin 10mg tab, benztropine mesylate 1mg, olanzapine 20mg and Tylenol 500mg. R5's record lacked evidence of documented disposition of medications for R5 to include: the name of the medication, strength, prescription number if applicable, quantity, to whom the medications were given, date of disposition, and the names of the staff and other individuals involved in the disposition. On September 4, 2025, at 12:45 p.m., clinical nurse supervisor (CNS)-C stated R5's medications would have been brought to the licensed assisted living director's (LALD)'s office and the LALD destroys or sends the medication with the resident. CNS-C stated they did not do	01910			

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01910	Continued From page 62 the medication destruction form; the LALD did that portion of R5's discharge. On September 4, 2025, at 12:46 p.m., licensed assisted living director (LALD)-D stated they had the medication destruction form at their office. LALD-D stated they will email it to the surveyor, however the surveyor did not receive the medication destruction form. The licensee's undated Medication Disposition or Disposal policy read, "1. Drugs Given to Residents When the Medication Management Services Have Been Terminated: a. A resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated; except that the conditions listed below must be met before controlled medications belonging to a resident will be given to the resident or the resident's representative. b. Staff will document in the resident's record the name of the person to whom the medications were given, the time and date, the name of each medication, dose, and the amount of medication remaining. c. When the resident and/or family do not take the medications with them, the facility will dispose of the medications following the steps outlined below. Medications to be disposed of will be listed, counted, and the person disposing of the medications will sign the note/form. This documentation will be in the resident record." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical, or nursing standards for three of three residents (R1, R3, R4) with hospital bed rails. This resulted in an immediate correction order on September 4, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On September 2, 2025, at approximately 12:20 p.m., during the facility tour, the surveyor observed a hospital style bed with upper half bilateral bed rails on R1, R3 and R4's bed. R1 R1 was admitted to the licensee on July 11, 2024, with diagnoses that included multiple sclerosis, altered mental status, neurocognitive	02310			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430			
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02310	Continued From page 64 disorder, and unspecified psychosis. R1's unsigned Service Plan with effective date of July 4, 2025, indicated R1 received services for bathing, dressing, grooming, incontinence care, medication administration, meal assistance, and home safety check. R1's Bed Safety Assessment completed on May 5, 2025, indicated the following: - The bedrails did not function as a restraint; - There was no high risk of injury if bed rails were in use; - There was no history of injury related to bed rails; - There were no medication prescribed that could affect mental status and increase the risk of injury with the use of bed rails; - Bed rails in use and no alternatives required; and - The bed rail meets the FDA guidelines. R1's record lacked assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition to include: - assessment of the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls; - assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance; - bed rail measurements and assessment that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations; and	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430			
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02310	Continued From page 65 - documentation that the risk virus benefit of using the bed rail was discussed with the resident. R3 R3 was admitted to the licensee on October 4, 2020, with diagnosis that included hyperlipidemia, chronic obstructive pulmonary disease, eating disorder, essential hypertension, morbid obesity, schizoaffective disorder, type 2 diabetes without complications, and congestive heart failure. R3's unsigned Service Plan with effective date of August 11, 2025, indicated R3 received services for bathing, ambulation, dressing, grooming, toileting, medication administration, meal assistance, and home safety check. R3's Bed Safety Assessment completed on May 5, 2025, indicated the following: - Standard bed frame and rails in use; - The bed rails did not function as a restraint; - There was no high risk of injury if bed rails were in use, it was being used to stabilize R3's gait when she gets out of bed; - There was no history of injury related to bed rails; - There were no medication prescribed that could affect mental status and increase the risk of injury with the use of bed rails; - Bed rails in use and no alternatives required; - Education had been provided to resident/responsible party of the risks and benefits of the bed rails and understanding was verbalized; and - The bed rail meets the FDA guidelines. R3's record lacked assessment of the bed rail upon initial installation, with each 90-day	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430			
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02310	Continued From page 66 assessment, or with a change of condition to include: - assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance; and - bed rail measurements and assessment that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. R4 R4 was admitted to the licensee on July 21, 2021, with diagnosis that included traumatic brain injury (TBI), back pain, chronic pain, chronic obstructive pulmonary disease, depression, iron deficiency anemia, myasthenia, osteoarthritis, peripheral vascular disease, seizure disorder, stroke, and unsteadiness. R4's unsigned Service Plan with effective date of August 12, 2025, indicated R4 received services for bathing, transfer assist, dressing, grooming, toileting, medication administration, and meal assistance, and home safety check. R4's Bed Safety Assessment completed on July 16, 2025, indicated R4 had standard bed fame with bilateral bed rails to assist with mobility and included the following: - Standard bed frame and rails in use; - The bed rails did not function as a restraint; - The rational for the bed rail was for mobility per resident preference; - Bed rail was appropriate based upon assessed needs; - There were no medication prescribed that could affect mental status and increase the risk of injury with the use of bed rails;	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
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02310	Continued From page 67 - Bedrails in use and no alternatives required; - Education had been provided to resident/ responsible party of the risks and benefits of the bed rails and understanding was verbalized; - Portable bed rails were installed and maintained according to manufacturer instruction and the consumer product safety commission site reviewed for any recall; - The bed safety zone assessment was not applicable; and - The bed rail meets the FDA guidelines. R4's record lacked assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition to include: - assessment of the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls; - assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance; and - bed rail measurements and assessment that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. On September 4, 2025, at 12:47p.m., clinical nurse supervisor (CNS)-C sated they did not understand what the bed safety zone was and did not know how often they were supposed to measure the zones. CNS-C stated they did not work for the licensee when the above residents admitted to the licensee's facility. On September 4, 2025, at 1:00 p.m., licensed	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
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02310	Continued From page 68 assisted living director (LALD)-D stated the above mentioned Bed Safety Assessments were all they had for bed rail assessment for all residents. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs) indicated, "Per the Uniform Assessment Tool, the need for assistive devices, such as bed rails, must be assessed upon initial installation, with each 90-day assessment and change of condition. (Please refer to Rule 4659.0150 where it directs assessment of mobility, including ambulation, transfers, and assistive devices.) Bed rail assessment should also be conducted whenever the type of bed rail is changed or if the rails is observed to not maintain a consistent secure attachment to the bed frame." Additionally, the FAQ indicated documentation of a bed rail should include but is not limited to: - purpose and intention of the bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to each resident's risks); - the resident's preferences; - physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. The licensee's undated Use of Side rails Policy indicated Side rails will not be used in the assisted living setting except in situations where assessment determines they are necessary for safety of the resident. If the resident or resident's	02310			

Minnesota Department of Health

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02310	Continued From page 69 representative wants side rails on the bed, facility RN will educate the resident/representative about the risks related to side rails and will assess whether the side rails meet FDA standards. If the side rails do not meet safety guidelines, staff will recommend alternative options to reduce the fall risk. Prescriber orders will be obtained for the side rails if indicated. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity. This had the potential to affect all of the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	03090			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 32730	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE W SERVICES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 4847 BRYANT AVENUE NORTH MINNEAPOLIS, MN 55430			
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03090	Continued From page 70 or has potential to affect a large portion or all the residents). The finding include: On September 2, 2025, at 10:42 a.m., the surveyor observed no notice to visitors regarding video surveillance at the enterance of the facility. On September 2, 2025, at 12:00 p.m., licensed assisted living director (LALD)-D stated the facility had video surveillance. LALD-D stated they thought they had the required posting for video surveillance on the door. Surveyor observed LALD-D open the door to check for the posting. LALD-D confirmed that there was no posting on the door and stated, "it used to be right here on the door, I think the maintenance guy took it down". On September 2, 2025, at 12:05 p.m., the surveyor observed signage posted in the dining room, which indicated the premises was protected by 24 hour audio and video surveillance; by entering you (the reader) agrees to be audio and video being recorded. The signage did not include the required verbatim language to indicate electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities. In addition, the signage was not posted at the entrance of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

STANTON HOUSE W SERVICES INC
4847 BRYANT AVENUE NORTH
Minneapolis, MN 55430
Hennepin County
Parcel:

Phone:

License Info

License: HFID 32730

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1005251116
Inspection Type: Full - Single
Date: 9/4/2025 Time: 10:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 2
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision

2-102.12AMN Priority Level: Priority 3 CFP#: 2

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

COMMENT: (ORIGINALLY ISSUED 08/02/22) THERE IS NO MN CFPM ON SITE. HAVE A FULL TIME EMPLOYEE COMPLETE AN APPROVED TRAINING COURSE AND APPLY FOR MN CFPM. INFORMATION SENT WITH REPORT.

Comply By: 10/01/2022 Originally Issued On: 9/4/2025

! New Order: 2-200 Employee Health

2-201.11C Priority Level: Priority 1 CFP#: 3

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.

COMMENT: THERE WAS NO EMPLOYEE ILLNESS LOG ON SITE. DISCUSSED RECORDING AND EXCLUSION REQUIREMENTS WITH THE PERSON IN CHARGE. BLANK LOG WILL BE EMAILED WITH REPORT.

Comply By: 9/4/2025 Originally Issued On: 9/4/2025

New Order: 3-500C Microbial Control: date marking

3-501.17B Priority Level: Priority 2 CFP#: 23

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

COMMENT: OPENED PACKAGES OF TCS FOODS, INCLUDING HOT DOGS AND MILK, WERE NOT MARKED WITH THE DATE THEY WERE OPENED. DATE MARK TCS FOODS AND USE OR DISCARD THEM WITHIN 7 DAYS.

Comply By: 9/4/2025 Originally Issued On: 9/4/2025

New Order: 4-300 Equipment Numbers and Capacities

4-302.12B Priority Level: Priority 2 CFP#: 36

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.

COMMENT: THERE WAS NO FOOD THERMOMETER ON SITE. PROVIDE A FOOD THERMOMETER TO MONITOR COLD HOLDING AND COOKING TEMPERATURES.

Comply By: 9/11/2025 Originally Issued On: 9/4/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

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

COMMENT: THE DISHWASHER ON SITE IS BROKEN AND STAFF HAVE BEEN USING A 3 COMPARTMENT BIN SYSTEM TO WASH, RINSE, AND SANITIZE DISHES AND EQUIPMENT. USING BINS IS A TEMPORARY SOLUTION ONLY AND THE FACILITY MUST REPAIR OR REPLACE THE DISHWASHER, OR INSTALL A 3-COMPARTMENT SINK WITH INTEGRALLY ATTACHED DRAINBOARDS AT EACH END, TO HAVE A DEDICATED AREA FOR WAREWASHING.

Comply By: 12/4/2025 Originally Issued On: 9/4/2025

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: THE LAMINATE FLOORING IS WORN THROUGHOUT THE KITCHEN, AND MISSING OR BADLY DAMAGED UNDER THE FRIDGE FROM A WATER LEAK. REPAIR OR REPLACE FLOORING TO BE SMOOTH AND EASILY CLEANABLE.

Comply By: 3/4/2026 Originally Issued On: 9/4/2025

Food & Beverage General Comment

INSPECTION COMPLETED WITH PERSON IN CHARGE AND REVIEWED WITH HRD NURSING EVALUATOR DEE MOSISSA.

DISCUSSED DATE MARKING, GLOVE USE, COOKING TEMPERATURES, CROSS-CONTAMINATION, AND EMPLOYEE ILLNESS.

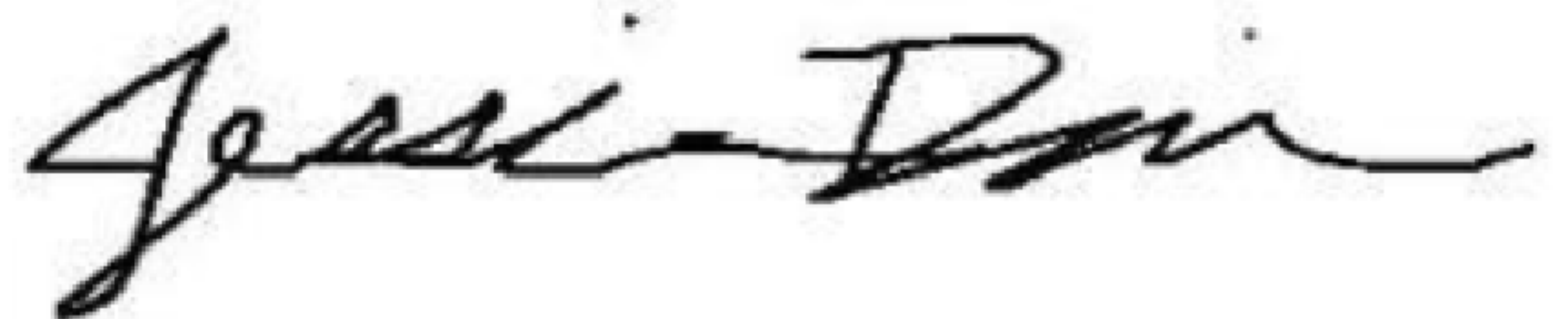
KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FACILITY NEEDS TO HAVE A DISHWASHER CAPABLE OF PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE, OR INSTALL A 3-COMPARTMENT SINK WITH INTEGRALLY ATTACHED DRAINBOARDS AT EACH END, FOR WAREWASHING.

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

I acknowledge receipt of the Metro District Office inspection report number F1005251116 from 9/4/2025

CARLOTTE MEAUX



Jessica Davis, REHS
Public Health Sanitarian 3
651-201-3961
jessica.davis@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

STANTON HOUSE W SERVICES INC
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1005251116
Inspection Type: Full
Date: 9/4/2025
Time: 10:00 AM

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** HOT DOG; **Temperature Process:** Cold-Holding

Location: REFRIGERATOR at 40 Degrees F.

Comment:

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
STANTON HOUSE W SERVICES INC	Report Number: F1005251116
Minneapolis	Inspection Type: Full
County/Group: Hennepin County	Date: 9/4/2025
	Time: 10:00 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** SANITIZER BIN

Location: KITCHEN SINK **Equal To** 200 PPM

Comment:

Violation Issued?: No