



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 21, 2025

Licensee

Stanton House With Services

3354 James Avenue North

Minneapolis, MN 55412

RE: Project Number(s) SL25977015

Dear Licensee:

On December 3, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 15, 2023, and the follow-up surveys completed on February 5, 2024; June 25, 2024, and September 30, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Benjamin J. Zwart'.

Benjamin J. Zwart, P.E., Supervisor

State Engineering Services Section

Health Regulation Division

Email: Benjamin.Zwart@state.mn.us

Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

November 20, 2024

Licensee
Stanton House With Services
3354 James Avenue North
Minneapolis, MN 55412

RE: Conditional License Number 417197
Health Facility Identification Number (HFID) 25977
Project Number(s) SL25977015

Dear Licensee:

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

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 60-day extension of your conditional license due to expire on **January 19, 2025**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on November 15, 2023, found not corrected at the time of the September 30, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0820-Fire Protection And Physical Environment-144g.45 Subd. 2 (g)

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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.

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>

CONDITIONAL LICENSE ISSUED:

MDH will extend the conditional assisted living facility license for Stanton House With Services for 60 calendar days from the date of this notice. At an unannounced point in time, within the 60 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Stanton House With Services is in substantial compliance.

The following conditions will continue to be in effect on the conditional assisted living facility license:

- a. **No new admissions:** Stanton House With Services will continue to not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition.
- b. **Egress Window Requirements:** Stanton House With Services will replace at least one window in occupied resident sleeping room #1, meeting the minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and have a window sill height from the floor to the clear opening of not more than 48 inches.

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

MDH will determine if Stanton House With Services is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 60-day conditional license period. If MDH determines Stanton House With Services is in substantial compliance on the follow up survey, MDH will remove the conditions from Stanton House With Services’ assisted living facility license, and Stanton House With Services will correct any outstanding violations identified during the survey. If Stanton House With Services is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Benjamin J. Zwart directly at: 651-201-3715.

Sincerely,

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

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 09/30/2024
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25977015-3 On September 30, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on June 25, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action needed.	{0 490}			

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{0 510}	Continued From page 2	{0 510}			
{0 510} SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}			
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a	{0 620}			

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{0 620}	Continued From page 3 vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this	{0 620}			

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{0 620}	Continued From page 4 information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: No further action needed.	{0 620}			
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the	{0 730}			

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{0 730}	Continued From page 5 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: No further action needed.	{0 730}			
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction.	{0 820}			

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{0 820}	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On September 24, 2024, at 7:03 a.m., the surveyor emailed licensed assisted living director (LALD)-C, during a desk follow up, requesting documentation the non-compliant existing emergency escape and rescue window in resident sleeping room 1 was replaced with a compliant minimum size clear opening window. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. On September 24, 2024, at 7:50 a.m., LALD-C, responded by email stating the non-compliant emergency escape and rescue opening window in resident sleeping room 1, was not replaced yet with a compliant minimum size clear opening window and she would follow up with the	{0 820}			

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{0 820}	Continued From page 7 contractor. On September 30, 2024, at 7:00 a.m., the surveyor had not received documentation the non-compliant existing emergency escape and rescue window was replaced with a compliant minimum clear opening size window. No further information was provided.	{0 820}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action needed.	{0 970}			
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	{01440}			

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{01440}	Continued From page 8 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action needed.	{01440}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;	{01470}			

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{01470}	Continued From page 9 (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01470}			

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{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action needed.	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted	{01620}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01620}	Continued From page 11 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action needed.	{01620}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet	{01760}			

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{01760}	Continued From page 12 the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action needed.	{01760}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address:	{01790}			

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{01790}	Continued From page 13 (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action needed.	{01790}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy	{01940}			

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{01940}	Continued From page 14 services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action needed.	{01940}			
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to	{01950}			

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{01950}	Continued From page 15 perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: No further action needed.	{01950}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action needed.	{01960}			

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{02310} SS=D	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: No further action needed.	{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: No further action needed.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF EXTENSION TO CONDITIONAL LICENSE

Electronically Delivered

July 15, 2024

Licensee

Stanton House With Services
3354 James Avenue North
Minneapolis, MN 55412

RE: Conditional License Number 417197
Health Facility Identification Number (HFID) 25977
Project Number(s) SL25977015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on June 25, 2024, to determine correction of orders found not corrected during the follow-up survey conducted February 5, 2024, pursuant to the survey completed November 15, 2023. Based on the follow-up survey results you were found to continue to not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is extending the conditional license 75-days, due to expire on **September 28, 2024**.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the follow-up survey, completed on February 5, 2024, found not corrected at the time of the June 25, 2024, follow-up survey is as follows:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment

The details of the violation noted at the time of this follow-up survey completed on June 25, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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.

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

To submit a reconsideration request, please visit:

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

CONDITIONAL LICENSE ISSUED:

MDH will issue Stanton House With Services an extension to the conditional assisted living facility license for 75 calendar days from the date of this notice. At an unannounced point in time, within the 75 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Stanton House With Services is in substantial compliance.

The following conditions will remain in effect through the extended conditional license period and apply to the conditional assisted living license:

- a. No new admissions:** Stanton House With Services will continue to not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition.
- b. Egress Window Requirements:** Stanton House With Services will replace at least one window in occupied resident sleeping room #1, meeting the minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and have a window sill height from the floor to the clear opening of not more than 48 inches.

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

MDH will determine if Stanton House With Services is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the extended 75-day conditional license period. If MDH determines Stanton House With Services is in substantial compliance on the follow up survey, MDH will remove the conditions from Stanton House With Services’ assisted living

facility license, and Stanton House With Services will correct any outstanding violations identified during the survey. If Stanton House With Services is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Tim Hanna directly at: 507-208-8982.

Sincerely,

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

Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

HHH

Minnesota Department of Health

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{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25977015-2 On June 25, 2024, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on February 5, 2024. At the time of the survey, there were 3 residents; all receiving services under the Assisted Living license. As a result of the follow-up survey, the following orders were reissued.	{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 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.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action needed.	{0 490}			
{0 510} SS=D	144G.41 Subd. 3 Infection control program	{0 510}			

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{0 510}	Continued From page 2 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}			
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not	{0 620}			

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{0 620}	Continued From page 3 required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	{0 620}			

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{0 620}	Continued From page 4	{0 620}			
	This MN Requirement is not met as evidenced by: No further action needed.				
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to 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	{0 730}			

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{0 730}	Continued From page 5 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: No further action needed.	{0 730}			
{0 820} SS=D	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	{0 820}			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 820}	Continued From page 6 Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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). Findings include: On a facility tour on June 25, 2024, at 1:00 p.m. with unlicensed personnel (ULP)-F, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms number 1. Occupied Resident Rooms Resident sleeping room number 1, emergency escape and rescue clear window opening measurements are 30 3/4 inches wide, 18 1/4 inches in height and 561 square inches in openable area. The window was measured with ULP-F, and survey staff present. The window was not changed since the last survey and did not meet the minimum requirements for clear opening height and minimum clear opening area. During an interview on June 25, 2024, 2024, at 1:10 p.m., ULP-F, stated completion and documentation of a fire watch and inspection log has continued since November 14, 2023. On June 25, 2024, at 1:15 p.m., ULP-F, provided	{0 820}			

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{0 820}	Continued From page 7 the completed fire watch documentation to the surveyor. It was explained to ULP-F, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. Windowsill height shall not be more than 48 inches from the floor to the clear opening. During an interview on June 25, 2024, at 1:15 p.m., ULP-F, stated the existing emergency escape and rescue window that does not meet the minimum clear opening size requirements in resident sleeping room number 1 had not been replaced. On June 25, 2024, at 9:10 a.m. licensed assisted living director (LALD)-C, provided an email stating the contractor that replaced the windows in resident rooms number 2 and 3 did not replace the existing emergency escape and rescue opening in resident room number 1 that does not meet the minimum clear opening size requirements in error. LALD-C, stated the windows would take 8 to 12 weeks for delivery and installation.	{0 820}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor	{0 970}			

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{0 970}	Continued From page 8 include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action needed.	{0 970}			
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action needed.	{01440}			

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{01470}	Continued From page 9	{01470}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this	{01470}			

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{01470}	Continued From page 10 subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01470}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not	{01530}			

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{01530}	Continued From page 11 provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action needed.	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for	{01620}			

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{01620}	Continued From page 12 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: No further action needed.	{01620}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action needed.	{01760}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for	{01790}			

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{01790}	Continued From page 13 the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;	{01790}			

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{01790}	Continued From page 14 (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action needed.	{01790}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;	{01940}			

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{01940}	Continued From page 15 (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action needed.	{01940}			
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions	{01950}			

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{01950}	Continued From page 16 in the resident's record; and This MN Requirement is not met as evidenced by: No further action needed.	{01950}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action needed.	{01960}			
{02310} SS=D	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: No further action needed.	{02310}			

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{03090}	Continued From page 17	{03090}			
{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: No further action needed.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

April 2, 2024

Licensee

Stanton House With Services
3354 James Avenue North
Minneapolis, MN 55412

RE: Conditional License Number 412742
Health Facility Identification Number (HFID) 25977
Project Number(s) SL25977015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on February 5, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **July 01, 2024**.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

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

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

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

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,000.00**. 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.

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

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

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

CONDITIONAL LICENSE ISSUED:

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

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

- a. No new admissions:** Stanton House With Services will not admit any new residents under its conditional assisted living facility license until MDH removes the “no new admissions” condition. Stanton House With Services must provide the Department:
 - i. A list of the names and birthdates of any individuals Stanton House With Services is currently in the process of admitting. These individuals will be able to continue the admittance process.
 - ii. A list of all current residents by location including:
 - 1. Name and birthdate of each resident
 - 2. Physical location of each resident
 - 3. Current payment source for services

4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
 5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative
- b. Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Stanton House With Services to correct the violations cited during the follow-up survey as well as to determine the overall practice of Stanton House With Services in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive licensed assisted living services. The OOLTC will share their findings with MDH.
- c. Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the license if MDH identifies any level 3 or 4 violations or widespread care related violations.
- d. Corrective Action Plan:** Stanton House With Services will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
 - i. A statement of the concern
 - ii. A description of what will happen to correct the concern
 - iii. A target date for when each correction will be complete
 - iv. Who is responsible to make sure it happens
 - v. Current status of correction work
 - vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order
- e. Health Facility Construction Permit:** Stanton House With Services, will contact The Minnesota Department of health and Industry (MNDLI) and obtain a construction permit for a health facility. Within 14-days from the date of this notice, Stanton House With Services, will provide MDH with a copy of the permit obtained from MNDLI.
- f. General Contractor:** Stanton House With Services must provide the following information to Bob Dehler (Robert.Dehler@state.mn.us) via email within 14-days of the date of this notice:
 - a. Contractor Name
 - b. License Number
 - c. Contract Information

- g. Egress Window Requirements:** Stanton House With Services will replace at least one window in occupied resident sleeping rooms #1, #2 and #3, meeting the minimum size requirements. At least one window in each resident bedroom must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width and have a windowsill height from the floor to the clear opening of not more than 48 inches.

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

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

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action. To submit a hearing request, please visit <https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

If you have any questions, please contact Bob Dehler directly at: 651-201-3710.

Sincerely,



Rick Michals, J.D.

Interim Assistant Division Director

**Minnesota Department of Health
Health Regulation Division**

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2024
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 000}	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25977015-1 On February 5, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 14, 2023. At the time of the survey, there were three residents; all of whom were recieving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{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 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.		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	{0 480}			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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{0 480}	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No further action needed.	{0 480}			
{0 490} SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: No further action needed.	{0 490}			
{0 510} SS=D	144G.41 Subd. 3 Infection control program	{0 510}			

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{0 510}	Continued From page 2 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: No further action needed.	{0 510}			
{0 620} SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not	{0 620}			

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{0 620}	Continued From page 3 required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.	{0 620}			

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{0 620}	Continued From page 4	{0 620}			
	This MN Requirement is not met as evidenced by: No further action needed.				
{0 730} SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to 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	{0 730}			

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{0 730}	Continued From page 5 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: No further action needed.	{0 730}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so	{0 780}			

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{0 780}	Continued From page 6 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on February 5, 2024, at 11:15 a.m. with licensed assisted living director (LALD)-C, the surveyor made the following observations of deficient smoke alarm requirements: The licensee failed to provide interconnected smoke alarms throughout the facility. During the tour the alarms were tested, and it was observed the smoke alarm in the hallway on the main floor and the smoke alarm in the basement were not interconnected with the other smoke alarms throughout the facility. Existing smoke alarms that	{0 780}			

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{0 780}	Continued From page 7 received power from the building electrical system are required to continue to receive power from the building electrical system. Additional required smoke alarms installed where building power is not provided at that location can be battery powered. All smoke alarms in the facility whether receiving power from the building electrical system or battery powered are required to be interconnected so activation of any one alarm activates all alarms in the facility. During an interview on February 5, 2024, at 11:30 a.m., LALD-C, stated the alarms should be interconnected but they were not.	{0 780}			
{0 800} SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	{0 800}			

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{0 800}	Continued From page 8 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on February 5, 2024, at 11:30 a.m., with licensed assisted living director (LALD)-C, the surveyor made the following observations of facility hazards and disrepair: Electrical outlet covers were missing on electrical outlets in resident room number 3 and in the main floor bathroom. It was not able to be verified the electrical cover that was missing in resident room number 2 during a tour on the previous survey was installed because of a bed in the way with a resident sleeping in the bed. Electrical outlet covers are required to be maintained as installed and approved at the time of construction approval in order to protect the building occupants from contact with live electrical wires. The cover was missing from the exhaust fan exposing the fan blades in the main floor bathroom. Bathroom exhaust fans and covers are required to be maintained according to manufactures installation instructions and as installed and approved at the time of construction approval. The bathroom exhaust fan cover is required to be maintained in place to protect the occupants from contact with the rotating metal fan blades. An awning window glass panel was broken in the	{0 800}			

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{0 800}	Continued From page 9 laundry room in the basement. Windows are required to be maintained as installed and approved at the time of construction approval. The clothes dryer was disconnected from the vent where it connects to the dryer in the laundry room in the basement. Dryer vents are required to vent the exhaust air from the dryer to the exterior of the facility to prevent moisture and lint particles from contaminating the air inside the facility. The ceiling light fixtures in the office area in the basement had open covers with exposed electrical wires and parts installed that were not original to the fixture manufacture. Three of the lights had fixture parts hanging and supported by the electrical wires. Electrical light fixtures are required to be maintained according to the light fixture manufactures installation instructions and the MN Electrical Code. During an interview on February 5, 2024, at 11:45 a.m., LALD-C, stated these deficient conditions had not yet been repaired and they would contact the facility maintenance personnel.	{0 800}			
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	{0 810}			

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{0 810}	Continued From page 10 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action needed.	{0 810}			
{0 820} SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/05/2024
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 820}	Continued From page 11 be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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). Findings include: On a facility tour on February 5, 2024, at 11:30 a.m. with licensed assisted living director (LALD)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms #1, #2, #3. Occupied Resident Rooms Resident sleeping room number 1, emergency escape and rescue clear window opening measurements are 30 3/4 inches wide, 18 1/4 inches in height and 561 square inches in openable area. The window was measured with	{0 820}			

Minnesota Department of Health

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{0 820}	Continued From page 12 LALD-C, and survey staff present. The window did not meet the minimum requirements for clear opening height and minimum clear opening area. Resident sleeping room number 2, emergency escape and rescue clear window opening measurements are 35 inches wide, 19 inches in height and 665 square inches in openable area. The window was measured with LALD-C and survey staff present. The window did not meet the minimum requirements clear opening height. Resident sleeping room number 3, emergency escape and rescue clear window opening measurements are 35 inches wide, 19 inches in height and 665 square inches in openable area. The window was measured with LALD-C and survey staff present. The window did not meet the minimum requirements clear opening height. On February 5, 2024, at 11:35 a.m., LALD-C, provided documentation of a fire watch policy and inspection log that was implemented on November 14, 2023, and has been maintained to date. It was explained to LALD-C that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. During an interview on February 5, 2024, at 11:35 a.m., LALD-C stated the windows had not been	{0 820}			

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{0 820}	Continued From page 13	{0 820}			
	replaced since the previous survey on November 14, 2023, but a contractor had measured for new windows on January 24, 2024, and will order and replace the windows when the new ones arrive.				
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action needed.	{0 970}			
{01440} SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.	{01440}			

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{01440}	Continued From page 14 (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: No further action needed.	{01440}			
{01470} SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of	{01470}			

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{01470}	Continued From page 15 Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: No further action needed.	{01470}			
{01530} SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the	{01530}			

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{01530}	Continued From page 16 following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: No further action needed.	{01530}			
{01620} SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days	{01620}			

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{01620}	Continued From page 17 from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action needed.	{01620}			
{01760} SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance	{01760}			

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{01760}	Continued From page 18 with the resident's medication management plan. This MN Requirement is not met as evidenced by: No further action needed.	{01760}			
{01790} SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's	{01790}			

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{01790}	Continued From page 19 medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: No further action needed.	{01790}			
{01940} SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written	{01940}			

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{01940}	Continued From page 20 statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: No further action needed.	{01940}			
{01950} SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by	{01950}			

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{01950}	Continued From page 21 the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: No further action needed.	{01950}			
{01960} SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: No further action needed.	{01960}			

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{02310}	Continued From page 22	{02310}			
{02310} SS=D	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: No further action needed.	{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: No further action needed.	{03090}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 28, 2023

Licensee

Stanton House With Services

3354 James Avenue North

Minneapolis, MN 55412

RE: Project Number(s) SL25977015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 15, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the 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. The MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

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

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

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

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5), the MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment.

The MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The MDH

An equal opportunity employer.

Letter ID: IS7N REVISED

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

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

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

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the 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/HRD-Appeals-Form>

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

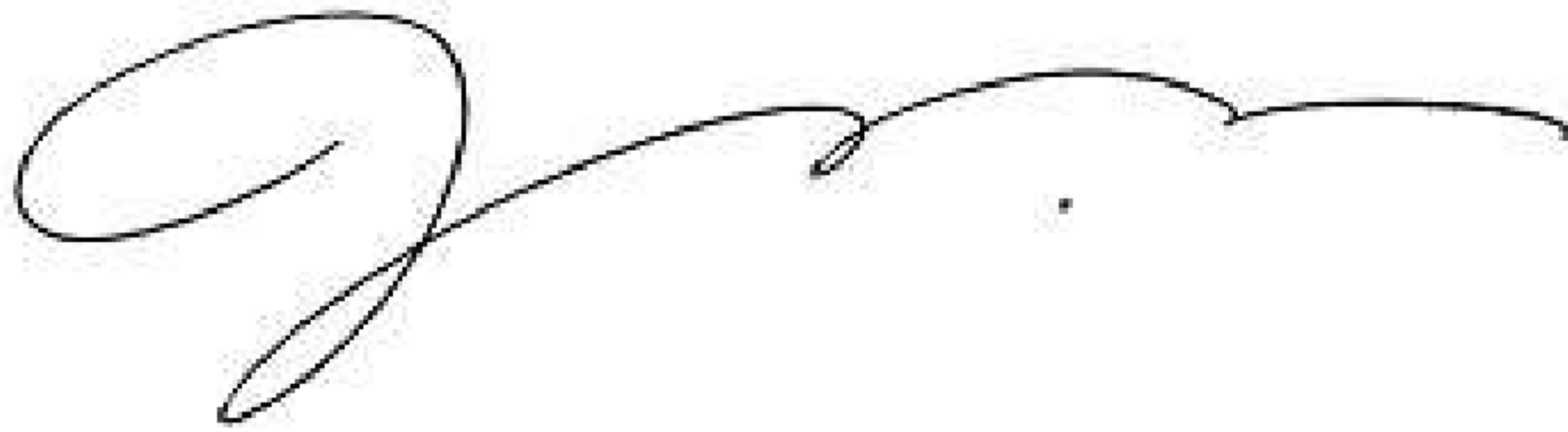
<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and 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 'Jess Schoenecker', with a stylized, flowing script.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/15/2023
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER 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: SL25977015-0 On November 13, 2023, through November 15, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two (2) active residents receiving services under the Assisted Living license. An immediate correction order was identified on November 14, 2023, issued for SL25977015-0, tag identification 0820. On November 15, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I.	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 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.		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the documents titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 13, 2023, and November 15, 2023, for the specific Minnesota Food Code violations. The Inspection Reports were provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide	0 490			

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0 490	Continued From page 2 direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents of the facility. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients).	0 490			

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0 490	Continued From page 3 The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G Tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). On November 13, 2023, at 10:00 a.m., during the entrance conference administrator (A)-E stated licensee had a daily program of social and recreational activities provided for the residents. From November 13, 2023, through November 15, 2023, during the course of the survey, R2 was not observed to be offered a daily program of social and recreational activities. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated licensee had not developed a daily program of social and recreational activities for the residents. LALD-C stated the residents were able to request activities, but licensee had not developed a schedule, a program, or offer activities to residents who resided under the licensee's care. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that	0 510			

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0 510	Continued From page 4 complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control related to glove use for one of two unlicensed personnel ((ULP)-A). 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-A was initially hired on February 28, 2023, and rehired on October 4, 2023. ULP-A's Home Health Aide Competency Evaluation dated March 1, 2023, indicated ULP-A had been educated and found competent with hand washing and infection control by the	0 510			

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0 510	Continued From page 5 registered nurse (RN). On November 14, 2023, at 8:40 a.m., observed ULP-A provide medication administration via a gastrointestinal tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition and medications) to R2. ULP-A donned (put on) gloves, failed to perform hand hygiene, then proceeded to provide medications to R2. When ULP-A completed the medication administration, ULP-A left R2's room, doffed (removed) their gloves, failed to perform hand hygiene, and proceeded to document the administration on the licensee's laptop computer in the common area. On November 14, 2023, at approximately 8:40 a.m., ULP-A stated they had been trained for proper infection control and glove use by clinical nurse supervisor (CNS)-D. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated CNS-D was responsible for training and maintaining licensee's infection control program and employee education. LALD-C stated licensee's expectations were hand hygiene would be completed before and after glove use. The licensee's undated Standard Precautions for All Health Care Workers policy indicated hand hygiene would be completed after removal of gloves. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 620	Continued From page 6	0 620			
0 620 SS=D	144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.	0 620			

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0 620	Continued From page 7 (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to comply with the requirements for reporting elopement for one of one discharged resident (R1) when the licensee was aware of the incident but did not report the incident to the 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 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	0 620			

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0 620	Continued From page 8 situation has occurred only occasionally). The findings include: R1 was admitted on February 13, 2023, and was discharged on August 31, 2023. R1's Weekly Care Note dated for the week of August 31, 2023, signed by administrator (A)-E read, "Staff reported that after lunch [R1] said [R1] had a bus ticket and his ride will be he (sic) to pick him up. Staff reported [R1] left at 1 pm. Girl friend picked him up. Staff said [R1] was going to Texas to leave (sic) with [R1's] brother." R1's Discharge Summary dated August 31, 2023, signed by A-E read, "No sure (sic) where [R1] went. [R1] was eating and taken (sic) medication before [R1] left." R1's Weekly Care Note dated for the week of September 8, 2023, signed by A-E read, "Follow/up (sic) - Brother confirmed that [R1] arrived to his house in Texas." On November 15, 2023, at 10:00 a.m., A-E stated R1 had eloped from the home and licensee believed R1 had gone to live with their brother in Texas. Surveyor requested a copy of the incident report and MAARC report that would be expected with an elopement (to leave a health-care facility without permission or authorization). On November 15, 2023, at 10:30 a.m., licensed assisted living director (LALD)-C and A-E stated licensee did not file a MAARC report as licensee was able to communicate with the brother and locate the resident. Surveyor reviewed licensee's policy with LALD-C and A-E which indicated a report would be filed with MAARC when a	0 620			

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0 620	Continued From page 9 resident's absence was not planned. LALD-C and A-E stated based on licensee's policy, a MAARC report should have been filed once licensee was aware of R1's elopement and intent to not return. The licensee's undated Missing Resident policy indicated if a resident's absence was unplanned, the registered nurse (RN) would immediately call the Common Entry Point (name for the previously used vulnerable adult reporting and replaced by MAARC). Additionally, the policy indicated once the resident was located, the RN or designee would contact Common Entry Point to report the incident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620			
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730			

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0 730	Continued From page 10 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document services were provided as identified on the service plan for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 730			

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0 730	Continued From page 11 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G Tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Discharge Orders and Information dated May 31, 2023, indicated R2 received bolus tube feeding five (5) times per day at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m. which replace meals. R2's record included two (2) documents titled Service Plan dated May 31, 2023, and both indicated R2 received services for meals, ADL (activities of daily living), assistance with dressing, eating, grooming, bathing, continence care, and transferring. R2's Activities of Daily Living Flowsheet dated November 2023, included a list of ADL services R2 could receive with column for staff to document when R2 received each service. On November 1, 2, 3, 4, 5, 10, 12, and 13, 2023, each column was completely blank with no documentation R2 received any services. R2's Activities of Daily Living Flowsheet indicated on November 6, 7, 8, 9, and 11, 2023,	0 730			

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0 730	Continued From page 12 documentation was placed that R2 received breakfast, lunch, and/or dinner (three meals). Additionally, on November 7, and 8, 2023, the document indicated R2 received the service of, "Turn in Bed." On November 14, 2023, at 9:30 a.m., observed unlicensed personnel (ULP)-A provide ADLs and transfer assistance to R2. ULP-A stated R2 needed, "lots of help," due to their medical diagnosis and abilities. After ULP-A provided services to R2, ULP-A did not document services provided. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated R2's Activities of Daily Living Flowsheet should have been documented on each day for all services provided. LALD-C stated staff would be reminded to document each shift when services are provided. The licensee's undated Resident Record policy indicated each resident's record would include documentation that services were provided as identified on the service plan. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 730			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780			

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NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 13 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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:	0 780			

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0 780	Continued From page 14 On a facility tour on November 14, 2023, at 12:45 p.m. with licensed assisted living director (LALD)-C, the surveyor made the following observations of deficient smoke alarm requirements: The licensee failed to provide smoke alarms in resident sleeping rooms #1, #2, #3, and the basement level of the facility. The only working smoke alarm was installed in the main floor hallway near the sleeping rooms. Smoke alarms are required to be installed inside all rooms used for sleeping, outside in the immediate area of the sleeping rooms and on each level of the facility. During an interview on November 14, 2023, at 12:45 p.m., LALD-C confirmed the deficient practice. TIME PERIOD FOR CORRECTION: Two (2) day	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790			

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0 790	Continued From page 15 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to store, maintain and inspect fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) 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 a facility tour on November 14, 2023, at 12:45 p.m., with licensed assisted living director (LALD)-C, it was observed the fire extinguisher provided in the kitchen had a date of last service of 2010. The fire extinguisher provided was also observed mounted 78 inches from the floor to the top of the extinguisher. At least one fire extinguisher with minimum 2-A:10-B:C (size) rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher or serviced annually by a certified technician.	0 790			

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0 790	Continued From page 16 During interview on November 14, 2023, at 12:45 p.m., LALD-C verified this deficient finding. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	0 800			

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0 800	Continued From page 17 On a facility tour on November 14, 2023, at 12:45 p.m., with licensed assisted living director (LALD)-C, the surveyor made the following observations of facility hazards and disrepair: Electrical outlet covers were missing on electrical outlets in resident room #2, #3, in the main floor bathroom, and in the office area in the basement. Electrical outlet covers are required to be maintained as installed and approved at the time of construction approval in order to protect the building occupants from contact with live electrical wires. The cover was missing from the exhaust fan exposing the fan blades in the main floor bathroom. Bathroom exhaust fans and covers are required to be maintained according to manufactures installation instructions and as installed and approved at the time of construction approval. The bathroom exhaust fan cover is required to be maintained in place to protect the occupants from contact with the rotating metal fan blades. An awning window glass panel was broken in the laundry room in the basement. Windows are required to be maintained as installed and approved at the time of construction approval. The clothes dryer vent was disconnected in the laundry room in the basement. Dryer vents are required to vent the exhaust air from the dryer to the exterior of the facility to prevent moisture and lint particles from contaminating the air inside the facility. The ceiling light fixtures in the office area in the basement had open covers with exposed electrical wires and parts installed that were not	0 800			

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0 800	Continued From page 18 original to the fixture manufacture. Electrical light fixtures are required to be maintained according to the light fixture manufactures installation instructions and the MN Electrical Code. Electrical cords and power strips were daisy chained (plugged into consecutive cords) and used to power space heaters and several other appliances in the office area in the basement. Electrical power cords are required to be used only for temporary power. One power strip that is not daisy chained is allowed to be used to power one appliance at a time or the office equipment at one desk station. On November 14, 2023, at 12:45 p.m., LALD-C verified the areas of disrepair and hazard. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall	0 810			

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0 810	Continued From page 19 receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain the facility's fire safety and evacuation plan with required content, make the plan readily available, provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During facility tour on November 14, 2023, at 1:30	0 810			

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0 810	Continued From page 20 p.m., the surveyor observed the fire safety and evacuation plan was not available in a central location in the facility at all times for all staff accessibility. Resident room numbers were not provided on or adjacent to the resident room doors. Resident room numbers that match the evacuation floor plan are required to be provided on or adjacent to the resident rooms for direction, reference, and communication in the event of an emergency. On November 14, 2023, at 1:30 p.m., licensed assisted living director (LALD)-C provided documents on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to include fire protection procedures necessary for residents for this facility in the event of a fire or similar emergency. Fire protection procedures necessary for residents in the event of a fire or similar emergency are required to be provided in writing in the fire safety policy. Record review of the available documentation indicated the licensee failed to provide unique and unusual needs for individual resident movement or evacuation during a fire or similar emergency. Documentation of unique and unusual needs for evacuation of each resident in the facility is required to be kept with the fire safety and evacuation plan for reference in the event of a fire or similar emergency. TRAINING Record review of the available documentation indicated the licensee did not offer specific	0 810			

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0 810	Continued From page 21 training based on the facility fire safety and evacuation plan to the residents. Resident training based on the resident actions required in the event of a fire or similar emergency is required to be offered to the residents and documented at least annually. DRILLS Record review of the available documentation indicated evacuation drills have been conducted but not in the required sequence. Documentation was provided for drills conducted once in January 2023 and once in June 2023. Evacuation drills are required to be completed and documented every other month and twice per shift per year and separately from employee training. Drills are required to be completed separately for each shift. During an interview on November 14, 2023, at 1:30 p.m., LALD-C verified the deficient practices. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 820 SS=I	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the	0 820			

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0 820	Continued From page 22 commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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). Findings include: On a facility tour on November 14, 2023, at 12:45 p.m. with licensed assisted living director (LALD)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms #1, #2, #3. Occupied Resident Rooms Resident sleeping room #1 emergency escape and rescue clear window opening measurements are 30 3/4 inches wide, 18 1/4 inches in height and 561 square inches in openable area. The window was measured with LALD-C, and survey staff present. The window did not meet the minimum requirements for clear opening height and minimum clear opening area.	0 820	This immediate correction order was identified on November 14, 2023, issued for SL25977015-0, tag identification 0820. On November 15, 2023, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of I. This was confirmed by the licensee via email and approved by evaluation supervisor.		

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0 820	Continued From page 23 Resident sleeping room #2 emergency escape and rescue clear window opening measurements are 35 inches wide, 19 inches in height and 665 square inches in openable area. The window was measured with LALD-C and survey staff present. The window did not meet the minimum requirements clear opening height. Unoccupied Room Resident sleeping room #3 emergency escape and rescue clear window opening measurements are 35 inches wide, 19 inches in height and 665 square inches in openable area. The window was measured with LALD-C and survey staff present. The window did not meet the minimum requirements clear opening height. It was explained to LALD-C that at least one compliant emergency escape and rescue opening is required within each resident sleeping room. Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. These deficient conditions were visually verified by LALD-C accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate.	0 820			

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0 970	Continued From page 24	0 970			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for the health, safety, or personal property of a resident. This had the ability to impact all residents who have signed an assisted living contract. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted on May 31, 2023. R2's Assisted Living Contract signed May 31, 2023, under Miscellaneous Provisions 1. Insurance Liability and Release section read, "The resident shall maintain at all times his or her own health, personal property, liability, automobile	0 970			

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0 970	Continued From page 25 (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request," and "The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage." On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated licensee was not aware the contract may not include a waiver for liability for the health and safety or personal property of a resident. LALD-C stated the language would be removed from the contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing	01440			

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01440	Continued From page 26 delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse completed delegated task supervision within 30 calendar days for one of one unlicensed personnel (ULP)-A. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was initially hired on February 28, 2023, and rehired on October 4, 2023. ULP-A's Medication Administration for the Home Health Aide dated February 28, 2023, was identified by administrator (A)-E as when ULP-A was trained and started providing medication administration when ULP-A was originally hired. ULP-A's Home Health Aide Competency Evaluation Additional Skills for Evaluation dated March 1, 2023, indicated ULP-A was trained and found competent for the delegated tasks of	01440			

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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
01440	Continued From page 27 oxygen, mechanical lifts, blood glucose monitoring, catheter care, and gastrostomy tube (commonly referred to as a g-tube) [illegible writing]. On November 14, 2023, at 8:10 a.m. and 8:40 a.m., observed ULP-A provide medication administration to both R3 and R2 respectively. ULP-A provided R3 oral medications and assisted R3 with management of their continuous positive airway pressure (CPAP) machine with oxygen. ULP-A provided R2 their medications where ULP-A crushed the medications, mixed with water, and inserted the mediations via a syringe into R2's g-tube. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C and A-E stated ULP-A was originally completed their training in March 2023, when ULP-A was originally hired. LALD-C stated ULP-A stopped working with licensee and then was rehired in October 2023, but new training was not completed as ULP-A demonstrated to the clinical nurse supervisor (CNS)-D, they remembered their original training. LALD-C stated CNS-D was responsible for completing the 30-day supervision of delegated tasks, but CNS-D had not completed it. LALD-C stated CNS-D would observe all ULPs who had delegated tasks but did not document specific direct 30-day supervision of the delegated tasks. The licensee's undated Supervision of Unlicensed Personnel policy indicated direct supervision must be completed by a qualified licensed health professional within 30 calendar days from when the employee began working for the facility and first performs the delegated task. Additionally, the policy indicated documentation of the direct supervision would be retained in each	01440			

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01440	Continued From page 28 employee's records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and	01470			

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01470	Continued From page 29 (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for one of one employee (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	01470			

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01470	Continued From page 30 of the residents). The findings include: ULP-A was initially hired on February 28, 2023, and rehired on October 4, 2023. ULP-A's Home Health Aide Competency Evaluation Additional Skills for Evaluation dated March 1, 2023, was identified by administrator (A)-E as ULP-A's orientation documentation. ULP-A's record lacked documentation ULP-A was orientated to Minnesota statutes related to assisted living. On November 14, 2023, at 8:10 a.m. and 8:40 a.m., observed ULP-A provide medication administration to both R3 and R2 respectively. ULP-A provided R3 oral medications and assisted R3 with management of their continuous positive airway pressure (CPAP) machine with oxygen. ULP-A provided R2 their medications where ULP-A crushed the medications, mixed with water, and inserted the mediations via a syringe into R2's g-tube. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C and A-E stated ULP-A was originally completed their training in March 2023, when ULP-A was originally hired. LALD-C stated ULP-A stopped working with licensee and then was rehired in October 2023, but new training was not completed as ULP-A demonstrated to the clinical nurse supervisor (CNS)-D they remembered their original training. LALD-C stated ULP-A's training included licensee's policies and procedures which referenced Minnesota statutes, but ULP-A was not specifically trained in the required statutes.	01470			

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01470	Continued From page 31 The licensee's undated Facility Employee Orientation policy indicated employee orientation would in an overview of Minnesota's home care law (MN Statues 144A.43 to 144.4798), which was the statutes the licensee previous operated under prior to converting to Minnesota Assisted Living statues (144G) on August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete.	01530			

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01530	Continued From page 32 Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received the required eight (8) hours of dementia care training prior to providing cares to residents for one of one employee (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A was initially hired on February 28, 2023, and rehired on October 4, 2023. ULP-A's Certificate of Completion dated October 4, 2023, indicated ULP-A completed four (4) hours of dementia care training. On November 14, 2023, at 8:10 a.m. and 8:40 a.m., observed ULP-A provide medication administration to both R3 and R2 respectively. ULP-A provided R3 oral medications and assisted R3 with management of their continuous positive airway pressure (CPAP) machine with oxygen. ULP-A provided R2 their medications where ULP-A crushed the medications, mixed with water, and inserted the mediations via a syringe	01530			

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01530	Continued From page 33 into R2's g-tube. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated licensee believed 4 hours of dementia related training was required for all employees. LALD-C stated all employees were provided with 4 hours of dementia related training prior to providing cares to residents. The licensee's undated Dementia Care Training policy indicated each employee would be provided eight (8) hours of dementia training prior to providing services to residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620			

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01620	Continued From page 34 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed comprehensive assessments to include all required content identified per Minnesota Administrative Rule 4659.0150 Uniform Assessment Tool for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Service Plan dated May 31, 2023, indicated	01620			

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01620	Continued From page 35 R2 received services for medication management, treatment management, assistance with meals, housekeeping, shopping, and activities of daily living (ADL) assistance for dressing, grooming, bathing, continence care, and transferring. R2's Client Skilled Reassessment/Supervisory Visit Records dated May 31, 2023, June 14, 2023, and September 14, 2023, respectively, were a two-page document identified by licensed assisted living director (LALD)-C as R2's RN assessments completed by clinical nurse supervisor (CNS)-D. The assessments were marked in multiple areas with a check box that read, "Unchanged from previous assessment," and lacked any data in those areas about R2's physical or cognitive assessment completed by CNS-D. The assessments failed to be developed and address the required content per Minnesota Administrative Rule 4659.0140 Subp. 2. B. (3). On November 15, 2023, at 11:30 a.m., LALD-C state licensee was not aware of the required content from the Uniform Assessment Tool as required in Minnesota Administrative Rule 4659.0150. LALD-C stated licensee had been using the same assessment for all residents and was used under the licensee's previous 144A Home Care statutes prior to converting to the current 144G Assisted Living statutes. LALD-C stated licensee had recently purchased a new electronic health record system and was in the process of converting from paper charts to electronic charts. LALD-C stated the new system would include the required content on all assessments.	01620			

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01620	Continued From page 36 The licensee's undated Nursing Assessment and Reassessment of Residents policy read, "the assessment includes but is not limited to the requirements outlined in MN Rules." No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620			
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medication administration was documented accurately for one of one resident (R2) who received medication management. 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	01760			

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01760	Continued From page 37 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Service Plan dated May 31, 2023, indicated R2 received services for medication management, treatment management, assistance with meals, housekeeping, shopping, and activities of daily living (ADL) assistance for dressing, grooming, bathing, continence care, and transferring. R2's medication administration record (MAR) dated November 1 - 30, 2023, included an order which read, "Chlorhexidine 0.12% sol (solution) 475 ml (milliliters) peridex swish & spit 15 ml by mouth twice daily." Next to the order were boxes to be initialed or documented on when R2 was administered the medication. On the dates of November 10, 11, and 12, 2023, no initials were placed on the HS (hour of sleep or sometimes called bedtime) time to document if R2 was administered the medication or if R2 had declined the medication and what actions were taken to address R2's decision to decline the medication. On the date of November 12, 2023, no initials were placed on the AM (morning) to document	01760			

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01760	Continued From page 38 the same. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C and administrator (A)-E stated they were not sure why initials were not placed on R2's MAR to document administration or if R2 declined the medication. LALD-C stated staff have all been trained on proper documentation for medication administration and actions to take if a resident declines a medication. The licensee's undated Documentation of Medication Management Services policy indicated all administrations or resident decline of medications would be documented in each resident's respected records at the time of occurrence. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to	01790			

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01790	Continued From page 39 the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed	01790			

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01790	Continued From page 40 personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented training and competencies for unlicensed personnel (ULP)-A who would provide medications for residents with unplanned time away from home when a licensed nurse was not available. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A was initially hired on February 28, 2023, and rehired on October 4, 2023. ULP-A's employee record lacked training and competencies for providing medications for residents with unplanned time away from home when licensed nurse was not available. On November 14, 2023, at 8:10 a.m. and 8:40 a.m., observed ULP-A provide medication administration to both R3 and R2 respectively.	01790			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/15/2023
NAME OF PROVIDER OR SUPPLIER STANTON HOUSE WITH SERVICES		STREET ADDRESS, CITY, STATE, ZIP CODE 3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01790	Continued From page 41 ULP-A provided R3 oral medications and assisted R3 with management of their continuous positive airway pressure (CPAP) machine with oxygen. ULP-A provided R2 their medications where ULP-A crushed the medications, mixed with water, and inserted the mediations via a syringe into R2's g-tube. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated licensee did not train employees on unplanned times away from home, but a policy would be used with direction from clinical nurse supervisor (CNS)-D via a phone call. LALD-C stated CNS-D would talk through the process with staff who contacted them when CNS-D was not present at the facility when a resident had an unplanned time away from home. The licensee's undated Medications for a Resident Who Will be Away from Facility when Medications are Scheduled indicated the RN would train and delegate unlicensed staff the task of giving medications for residents with unplanned times away from home. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01790			
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services	01940			

Minnesota Department of Health

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01940	Continued From page 42 that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to include a written statement of a treatment service on the resident's service plan for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01940			

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01940	Continued From page 43 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Service Plan dated May 31, 2023, lacked written statements of the treatment or therapy to be provided to the resident. The service plan included a document titled Treatment Plan which read, "See attached treatment plan." On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated R2's service plan lacked written statements for the treatment or therapy licensee provided. LALD-C no other treatment plan as identified on the service plan was developed and R2's treatments related to G-tube would need to be added to the service plan. The licensee's undated Treatment and Therapy Management Plan policy indicated any treatment or therapy provided by the licensee would be included in each resident's service plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01940			

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01950	Continued From page 44	01950			
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record for one of one resident (R2) who had an ordered treatment. 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	01950			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 25977	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/15/2023
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01950	Continued From page 45 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Discharge Orders and Information dated May 31, 2023, indicated R2 required durable medical equipment (DME) related to tube feeding supplies, dressings, and specific instructions for management of a G-tube such as documentation of the number at the bumper on the side of the G-tube to monitor for placement. On November 13, 2023, at 12:45 p.m., observed unlicensed personnel (ULP)-A disconnect R2's G-tube feeding and flush G-tube with water. ULP-A stated flushing the G-tube was important to prevent complications such as clogging, and the water was also part of R2's hydration needs as R2 did not take fluids by mouth. ULP-A stated specific instructions for the dressing change and when to contact a licensed health care professional were not included in R2's record but ULP-A stated clinical nurse supervisor (CNS)-D provided training and demonstration to ULP-A on the proper methods for G-tube management. On November 15, 2023, at 11:30 a.m., CNS-D stated each employee was trained on R2's G-tube management and when to contact a health care professional, but CNS-D stated no specific instructions were maintained in R2's	01950			

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01950	Continued From page 46 record where an ULP would be able to refer to them. The licensee's undated Treatment and Therapy Management Plan policy indicated specific written instructions for all treatment or therapy residents received would be included in resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of the administration of a treatment or therapy was completed for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a	01960			

Minnesota Department of Health

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01960	Continued From page 47 client'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 clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Discharge Orders and Information dated May 31, 2023, indicated R2 required durable medical equipment (DME) related to tube feeding supplies, dressings, and specific instructions for management of a G-tube such as flushing the G-tube to maintain patency (prevent clogging). On November 13, 2023, at 12:45 p.m., observed unlicensed personnel (ULP)-A disconnect R2's G-tube feeding and flush G-tube with water. ULP-A stated flushing the G-tube was important to prevent complications such as clogging, and the water was also part of R2's hydration needs as R2 did not take fluids by mouth. R2's medication administration record (MAR) dated November 1-30, 2023, read, "Flush GT (G-Tube) with 120 ml's (milliliters) of water - 60 before and 60 ml after feeding is done x 5 times," and space to document each day at 6:00 a.m., 10:00 a.m., 2:00 p.m., 6:00 p.m., and 10:00 p.m. were in place. R2's MAR lacked documentation for all days on the 10:00 p.m. line. On November	01960			

Minnesota Department of Health

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01960	Continued From page 48 9, 10, 11, 12, and 13, 2023, the MAR included blank spaces for multiple administration times. Additionally, R2's MAR read, "Clean GT site with soap and water daily and apply 4x4 as needed. Secure with tape to prevent pulling," with space to document scheduled at 6:00 p.m. R2's MAR lacked documentation on November 1-5, and 10-13, 2023, at 6:00 p.m., if the cleaning and dressing treatment was completed. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated licensee's expectations was all treatments are to be documented when completed and if not completed, why they were not completed, and actions taken. LALD-C stated they were not sure why blank areas were included in R2's record, and clinical nurse supervisor (CNS)-D would be investigating the lacking documentation. The licensee's undated Treatment and Therapy Management Plan policy indicated all treatments or therapies would be documented by the person who completed them, and if the treatments or therapies would not completed, documentation as to why they were not and actions taken to remedy the situation. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960			
02310 SS=D	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	02310			

Minnesota Department of Health

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02310	Continued From page 49 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 one of one resident (R2) with bed rails (also referred to as side rails). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted on May 31, 2023, and required total assistance related to a cerebrovascular accident (CVA or commonly referred to as a stroke) and management of a gastrostomy tube (commonly called a G-tube which is a tube that is inserted through the skin into the stomach to provide nutrition/meals and medications). R2's Restraints: Side Rail Utilization Assessment signed by clinical nurse supervisor (CNS)-D dated June 7, 2023, section Side Rail Prevention/Reduction Committee Recommendations section was not completed and lacked identification if side rails were indicated for R2's use. The assessment lacked	02310			

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02310	Continued From page 50 measurements in the specified areas as required by the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, developed by the United States Food and Drug Administration (FDA) to prevent injury or death when side rails are utilized. On November 13, 2023, at 1:20 p.m., CNS-D stated measurements were not recorded in R2's record. CNS-D stated they were not sure why the final section of the assessment was not completed. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated measurement and a completed side rail assessment was required to be completed for all residents who utilize side rails. LALD-C stated licensee was not sure why the assessment was not completed fully and lacked the required measurements as licensee was aware of the requirements from the FDA. The licensee's undated Use of Side Rails policy indicated the assessments and measurements would be completed per the FDA's guidance prior to the utilization of any side rails for any resident. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	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	03090			

Minnesota Department of Health

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03090	Continued From page 51 cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that has not potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 13, 2023, at 10:00 a.m., upon entering the facility, the surveyor observed three entrances accessible by visitors to the facility, but each lacked the required notice for electronic monitoring. On November 13, 2023, at approximately 11:00 a.m. during a facility tour, multiple cameras were noted throughout the facility. On November 15, 2023, at 11:30 a.m., licensed assisted living director (LALD)-C stated licensee was not aware of the required verbatim notice to	03090			

Minnesota Department of Health

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03090	Continued From page 52 be posted at each entrance accessible by visitors. LALD-C stated the required postings would need to be placed at each entrance. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			

Type: Follow-Up
Date: 11/15/23
Time: 12:26:27
Report: 1013231275

Food and Beverage Establishment Inspection Report

Page 1

Location:

Stanton House With Services
3354 James Avenue North
Minneapolis, MN55412
Hennepin County, 27

Establishment Info:

ID #: 0037769
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125219543
ID #:

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

The following orders previously issued on 11/13/23 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-301.12A **** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

THE FACILITY DOES NOT HAVE A DISH MACHINE OR A 3-COMPARTMENT SINK FOR MANUAL WARE WASHING. STAFF USE 3 CONTAINERS TO WASH, RINSE, AND SANITIZE WARE. DISCUSSED WARE WASHING PROCEDURES WITH STAFF.

Issued on: 11/13/23

Comply By: 03/01/24

4-300 Equipment Numbers and Capacities

4-302.12A **** Priority 2 ****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD PROBE THERMOMETER WAS AVAILABLE. TCS FOODS ARE STORED, AND RAW MEATS/EGGS ARE COOKED ON-SITE. DISCUSSED THERMOMETER USE WITH STAFF.

Issued on: 11/13/23

Comply By: 11/17/23

2-100 Supervision

2-102.12AMN

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

NO MN CFPM IS EMPLOYED AT THE FACILITY. THE MN CFPM INFORMATION WAS PROVIDED.

Issued on: 11/13/23

Comply By: 02/13/24

Type: Follow-Up
Date: 11/15/23
Time: 12:26:27
Report: 1013231275
Stanton House With Services

Food and Beverage Establishment
Inspection Report

4-600 Cleaning Equipment and Utensils
4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
GREASE AND GRIME BUILD UP WAS LOCATED ON THE KITCHEN RANGE AND OVEN.
DISCUSSED CLEANING PROCEDURES WITH STAFF.
11/15/23
THE OPERATOR PLANS TO REPLACE THE RANGE/OVEN BY 3/1/24.
Issued on: 11/13/23 Comply By: 11/13/23

No NEW orders were issued during this inspection.

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

The operator emailed pictures to correct previous orders. MN Rule 4626.0715 and MN Rule 4626.0620A were cleared.

Discussed food safety and food handling procedures.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231275 of 11/15/23.

Certified Food Protection Manager: _____
Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: _____
Terra Ross
Operator

Signed:  _____
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us

Type: Full
Date: 11/13/23
Time: 12:00:00
Report: 1013231266

Food and Beverage Establishment Inspection Report

Page 1

Location:

Stanton House With Services
3354 James Avenue North
Minneapolis, MN 55412
Hennepin County, 27

Establishment Info:

ID #: 0037769
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125219543
ID #:

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

The following orders were issued during this inspection.

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

3-302.11A(1)

**** Priority 1 ****

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

CARTONS OF RAW SHELL EGGS WERE STORED ON THE TOP SHELF OF THE KITCHEN REFRIGERATOR ABOVE READY-TO-EAT FOOD (MILK, JUICE, CHEESE) AND FULLY COOKED HOT DOGS. COMPLY WITH ABOVE RULE. DISCUSSED FOOD STORAGE WITH STAFF AND RAW EGGS MOVED BELOW AND AWAY.

Corrected on Site

4-300 Equipment Numbers and Capacities

4-301.12A

**** Priority 2 ****

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

THE FACILITY DOES NOT HAVE A DISH MACHINE OR A 3-COMPARTMENT SINK FOR MANUAL WARE WASHING. STAFF USE 3 CONTAINERS TO WASH, RINSE, AND SANITIZE WARE. DISCUSSED WARE WASHING PROCEDURES WITH STAFF.

Comply By: 03/01/24

4-300 Equipment Numbers and Capacities

4-302.12A

**** Priority 2 ****

MN Rule 4626.0705A Provide a readily accessible food temperature measuring device to ensure attainment and maintenance of food temperatures.

NO FOOD PROBE THERMOMETER WAS AVAILABLE. TCS FOODS ARE STORED, AND RAW MEATS/EGGS ARE COOKED ON-SITE. DISCUSSED THERMOMETER USE WITH STAFF.

Comply By: 11/17/23

Type: Full
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4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

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

CHLORINE SANITIZER IS USED TO SANITIZE WARE IN THE KITCHEN. NO CHLORINE TEST KIT WAS AVAILABLE. DISCUSSED SANITIZER TEST KIT USE.

Comply By: 11/20/23

2-100 Supervision

2-102.12AMN

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

NO MN CFPM IS EMPLOYED AT THE FACILITY. THE MN CFPM INFORMATION WAS PROVIDED.

Comply By: 02/13/24

4-200 Equipment Design and Construction

4-204.112A

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

NO THERMOMETERS WERE LOCATED IN THE FACILITY'S REFRIGERATORS OR FREEZERS.
COMPLY WITH RULE.

Comply By: 11/17/23

4-600 Cleaning Equipment and Utensils

4-601.11C

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

GREASE AND GRIME BUILD UP WAS LOCATED ON THE KITCHEN RANGE AND OVEN.
DISCUSSED CLEANING PROCEDURES WITH STAFF.

Comply By: 11/13/23

Surface and Equipment Sanitizers

Chlorine: = 100 ppm at Degrees Fahrenheit

Location: Sanitizer container - manual ware wash

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Raw shell eggs

Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator

Violation Issued: No

Process/Item: Cheese

Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator

Violation Issued: No

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Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Kitchen refrigerator
Violation Issued: No

Process/Item: Fish
Temperature: 19 Degrees Fahrenheit - Location: Freezer 1
Violation Issued: No

Process/Item: Sausage
Temperature: 12 Degrees Fahrenheit - Location: Freezer 2
Violation Issued: No

Process/Item: Waffles
Temperature: 26 Degrees Fahrenheit - Location: Freezer 3
Violation Issued: No

Process/Item: Eggs
Temperature: 40 Degrees Fahrenheit - Location: Basement refrigerator
Violation Issued: No

Process/Item: Milk
Temperature: 41 Degrees Fahrenheit - Location: Basement refrigerator
Violation Issued: No

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

The inspection was completed with the on-site staff and reviewed with MDH Nurse Evaluator B. Mueller.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tile floor, painted walls, laminate counter top, and a painted ceiling.

A two basin sink is located in the kitchen. A modular hand washing sink with a foot pump is located in the kitchen and designated for hand washing.

No dish machine or 3-compartment sink is located in the facility. Staff wash, rinse, and sanitize ware using large containers. Reviewed ware wash procedures with staff.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1013231266 of 11/13/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed:_____
Terra Ross
Operator

Signed:_____ 
Jerry Malloy
Sanitarian Supervisor
FPLS Metro
651-201-3998
jerry.malloy@state.mn.us