Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 27, 2024

Licensee
The Alton
1306 Alton Street
Saint Paul, MN 55116

RE: Project Number(s) SL25829016

Dear Licensee:

On June 4, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your agency to determine correction of orders found on the survey completed on March 7, 2024. The follow-up survey determined your agency had not corrected all of the state licensing orders issued pursuant to the March 7, 2024 survey.

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

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last survey, completed on March 7, 2024, found not corrected at the time of the June 4, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0660 - Tuberculosis Prevention And Control - 144g.42 Subd. 9 - $500.00

The details of the violations noted at the time of this follow-up survey completed on June 4, 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.

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(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.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.

Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144A.474, Subd. 12, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 business days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144A.44 Subd. 1(14), 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. § 144A.474, Subd. 11 (g), a home care 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. § 144A.475, subd 4 and Subd. 7, a request for a hearing must be in writing and received by MDH within 15 calendar days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit **https://forms.web.health.state.mn.us/form/HRDAppealsForm**.

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

We urge you to review these orders carefully. If you have questions, please contact Renee Anderson at 651-201-5871.

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

Sincerely,

Renee L Anderson, Supervisor
State Evaluation Team
Email: Renee.L.Anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290
AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	R 06/04/2024

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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: Project # SL25829016-1 On June 3, 2024, through June 5, 2024, the Minnesota Department of Health conducted a follow up survey with the above provider to follow-up on orders issued pursuant to a survey completed on March 7, 2024. At the time of the survey, there were 41 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{0 000}		
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and	{0 480}		

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{0 480}	Continued From page 1 This MN Requirement is not met as evidenced by: No further action required.	{0 480}		
{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 required.	{0 510}		
{0 550} SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also	{0 550}		

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{0 550}	Continued From page 2 state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: No further action required.	{0 550}		
{0 650} SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}		

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{0 650}	Continued From page 3 No further action required.	{0 650}		
{0 660} SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single Interferon-Gamma Release Assay (IGRA) blood test was completed and documented for three of three employees (unlicensed personnel (ULP)-O, ULP-P, ULP-Q). 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	{0 660}		

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{0 660}	Continued From page 4 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: ULP-O, ULP-P, ULP-Q were hired April 9, 2024, April 15, 2024, and April 30, 2024, respectively, to provide direct cares for the licensee's residents. ULP-O, ULP-P, ULP-Q's employee records each contained a symptom and history screening form but lacked documentation of a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. On May 4, 2024, at 3:15 p.m., licensed assisted living director (LALD)-C stated via email, "we are unable to locate further documentation for the two step Mantoux." LALD-C further stated the previous RN had been doing them, but they were unable to find the records. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the	{0 660}		

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{0 660}	Continued From page 5 HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's 8.16 Tuberculosis Screening policy dated February 10, 2024, included "[Licensee] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report (MMWR)." The policy further indicated under Staff Screening, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs; 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs; 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; 4. Staff TB screening results will be kept in each employee medical file; and 5. Staff should be screened for signs and symptoms on an annual basis."	{0 660}		

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{0 660}	Continued From page 6 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	{0 660}		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: No further action required.	{0 680}		

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{0 730}	Continued From page 7	{0 730}		
{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 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	{0 730}		

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{0 730}	Continued From page 8 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 required.	{0 730}		
{01470} SS=D	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;	{01470}		

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{01470}	Continued From page 9 (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 required.	{01470}		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring	{01620}		

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{01620}	Continued From page 10 (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: No further action required.	{01620}		
{01640} SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The	{01640}		

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{01640}	Continued From page 11 service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: No further action required.	{01640}		
{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	{01760}		

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{01760}	Continued From page 12 by: No further action required.	{01760}		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: No further action required.	{01890}		
{02170} SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care	{02170}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	R 06/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(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
{02170}	Continued From page 13 plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: No further action required.	{02170}		
{02350} SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: No further action required.	{02350}		

Electronically Delivered

April 3, 2024

Licensee
The Alton
1306 Alton Street
Saint Paul, MN 55116

RE: Project Number(s) SL25829016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 7, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

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

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

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this

section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Renee L. Anderson

Renee Anderson, Supervisor
State Evaluation Team
Email: renee.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(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: SL25829016-0 On March 4, 2024, through March 7, 2024, the Minnesota Department of Health conducted a CHOW (change of ownership) survey at the above provider, and the following correction orders were issued. At the time of the survey there were 44 residents, all of whom were receiving services under the provider's Assisted Living Facility with Dementia Care license. Immediate correction orders were identified on March 4, 2024, issued for SL25829016, tag identification 1290 and 2310. On March 5, 2024, the immediacy of correction orders 1290 and 2310 were removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 6, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 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 2 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, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control. The licensee failed to ensure direct care staff appropriately gloved and performed adequate hand hygiene for one of four staff (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired August 26, 2021, to provide direct cares for the licensee's residents. On March 4, 2024, at 12:45 p.m., ULP-D was observed providing cares to R1. ULP-D	0 510		

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0 510	Continued From page 3 performed hand hygiene with alcohol-based hand sanitizer, donned gloves, and assisted R1 into the bathroom in a wheelchair. ULP-D assisted R1 into a standing position, pulled R1's pants down, and transferred R1 to the toilet. ULP-D removed R1's wet brief and placed it into a trash bin, then placed a new brief on R1. ULP-D assisted R1 back to a standing position, cleansed R1's perineal area (the area of the pelvis occupied by the urinary and genital ducts and rectum) with cleansing wipes, and placed the wipes in the trash bin. ULP-D pulled up R1's pants and assisted her back into the wheelchair. Without removing their gloves, ULP-D pushed R1 in her wheelchair to the commons area next to a reclining chair and reshaped a pillow on the chair. ULP-D suggested R1 sit in the recliner but R1 declined. ULP-D left R1 in the wheelchair and returned to R1's room. ULP-D retrieved the trash from the bin in the bathroom and placed it in a larger trash container with a lid, located in the main kitchen area. ULP-D doffed their gloves, threw them into the trash container in the kitchen area and washed their hands in the kitchen sink. On March 4, 2024, at 1:15 p.m., ULP-D stated she had been trained on infection control which included hand washing and glove technique. On March 6, 2024, at 1:00 p.m., clinical nurse supervisor (CNS)-A stated the ULPs were expected to perform HH and change gloves throughout cares. The CDC guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated November 29, 2022, indicated healthcare personnel (HCP) should perform hand hygiene immediately before touching a patient, after	0 510		

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0 510	Continued From page 4 touching a patient or the patient's immediate environment and immediately after glove removal. The licensee's hand washing policy, dated February 10, 2024, indicated hand hygiene would be performed by all employees between tasks and procedures. The policy further indicated hand hygiene should be completed after touching garbage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by:	0 550		

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0 550	Continued From page 5 Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 4, 2024, at 10:22 a.m., the surveyor observed facility postings located in the entryway vestibule, and the first-floor common areas shared by residents, staff, and visitors of the facility. The facility lacked the required posting of the grievance procedure to include the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to MAARC. -at 10:30 a.m., the surveyor observed the licensed assisted living director (LALD)-C placing additional postings in the entryway vestibule of	0 550		

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0 550	Continued From page 6 the facility. LALD-C stated, she was posting the required facility postings which had been in a hanging file inside the first-floor conference room. In addition, LALD-C verbalized she last worked at the facility on February 29, 2024, and planned to get the required information posted. The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated February 10, 2024, included "[Licensee] will post information for reporting suspected crime and maltreatment. The facility will support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: b. Posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult." The licensee's 2.10 Complaint / Grievance Posting policy dated February 10, 2024, included "1. [Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled	0 650		

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0 650	Continued From page 7 volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure employee records contained the required content for one of two employees, unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	0 650		

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0 650	Continued From page 8 ULP-D was hired August 26, 2021, to provide direct cares for the licensee's residents. On March 4, 2024, during a continuous observation from 12:45 p.m., to 1:15 p.m., ULP-D assisted R1 with personal cares and R2 and R3 with medication administration. ULP-D stated she had in-person training with the registered nurse (RN) on medication administration and had also completed online education. ULP-D's employee record lacked documentation of the following required training and competency evaluation completed by a RN: -documentation requirements for all services provided; -reports of changes in the client's condition to the supervisor designated by the home care provider; -maintenance of a clean and safe environment; -training on the prevention of falls for providers working with the elderly or individuals a risk for falls; -medication, exercise, and treatment reminders; -understanding appropriate boundaries between staff and residents and resident's family; -procedures to utilize in handling various emergency situations; -awareness of commonly used health technology equipment and assistive devices; -observation, reporting and documenting of client status; -basic knowledge of body functioning and change in body functioning, injuries or other observed changes that must be reported to appropriate personnel; -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; and -administering medications or treatments as	0 650		

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0 650	Continued From page 9 required. On March 6, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated she had done the medication training and competency with ULP-D but was unsure where the documentation was. -at 1:00 p.m., manager assistant (MA)-L stated they had contacted the previous owner of the facility and requested missing training and evaluation records for ULP-D but had not received them yet. The licensee's 5.02 Competency Training Evaluations, dated February 10, 2024, indicated training and competency of the ULPs would be conducted by an RN and would include the above required content. The policy further indicated a copy of all education, training, and competency testing would be kept in the employee's personnel file. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees,	0 660		

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0 660	Continued From page 10 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either by a two-step tuberculin skin test (TST) or a single Interferon-Gamma Release Assay (IGRA) blood test was completed and documented for one of two employees (unlicensed personnel (ULP)-H). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: ULP-H was hired December 14, 2023, to provide direct cares for the licensee's residents. On March 5, 2024, at 6:00 a.m., the surveyor observed ULP-H provide toileting assistance for R7. ULP-H's employee record contained a negative	0 660		

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0 660	Continued From page 11 TB QuantiFERON blood test dated December 1, 2021, greater than 90 days prior to ULP-H's hire date. On March 6, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A and manager assistant (MA)-L stated, they were aware ULP-H's TB QuantiFERON blood test was not completed within 90 days from hire date. In addition, CNS-A verbalized she planned to ensure the licensee had the required testing in the employee records. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. The licensee's 8.16 Tuberculosis Screening policy dated February 10, 2024, included "[Licensee] will establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity	0 660		

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0 660	Continued From page 12 and Mortality Weekly Report (MMWR)." The policy further indicated under Staff Screening, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs; 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs; 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented; 4. Staff TB screening results will be kept in each employee medical file; and 5. Staff should be screened for signs and symptoms on an annual basis." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 13 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 680		

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0 680	Continued From page 14 The findings include: On March 4, 2024, at 10:22 a.m., the surveyor observed the facility postings located in the entryway vestibule, and the first-floor common areas shared by residents, staff, and visitors of the facility. The area lacked the required posting of the facility emergency preparedness plan. -at 10:30 a.m., the surveyor observed the licensed assisted living director (LALD)-C place postings in the entryway vestibule of the facility. LALD-C stated, she was posting the required facility postings which had been located in a hanging file inside the first-floor conference room. In addition, LALD-C verbalized she last worked at the facility on February 29, 2024, and planned to get the required information posted. The licensee's EPP dated November 30, 2023, lacked the following requirement: -post an emergency disaster plan prominently. The licensee's 9.02 Disaster Planning and Emergency Preparedness policy dated February 10, 2024, included "[Licensee] will have in place a general emergency preparedness plan, that is in alignment with facility's requirement to also comply with CMS Appendix Z. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident:	0 730		

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0 730	Continued From page 15 (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service	0 730		

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0 730	Continued From page 16 termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included accurate documentation that services had been provided as identified in the service plan for one of four residents (R8). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R8 was admitted on October 5, 2020, and had diagnoses to include dementia, anxiety, and peripheral vascular disease (a progressive circulation disorder). R8's signed service plan dated February 28, 2023, indicated R8 received services to include assistance with the following: -bathing, effective date of February 4, 2021, for 30 scheduled minutes every week on Wednesday at 7:00 p.m. R8's unsigned service plan, printed March 5, 2024, at 9:31 a.m., during the survey, indicated R8 received services to include assistance with	0 730		

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0 730	Continued From page 17 the following: -bathing, effective date of November 29, 2022, for 70 scheduled minutes daily at 4:00 p.m. R8's service detail report for February 1, 2024, to February 29, 2024, included the following documentation of bathing services provided: -February 1-6, 8-11, 16-17, 20, 22, 23, 25-28: 70 minutes of bathing assistance daily; -February 7, 14, 21: zero minutes of bathing assistance; -February 12, 15, 18-19, 24, 29: one minute of bathing assistance daily; and -February 13: three minutes of bathing assistance. R8's medical record documented 19 of 29 days in February 2024, where R8 received 70 minutes of bathing assistance at 4:00 p.m., daily. On March 6, 2024, at 10:30 a.m., the surveyor observed a document located in the resident assistant (RA) resource binder located on third floor titled "3rd floor shower list." The document indicated R8's shower day was scheduled for Sundays at 3:30 p.m. On March 6, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-A stated, R8 had not received 70 minutes of bathing assistance for 19 days in the month of February. Also, CNS-A verbalized there must be an error on R8's service plan which documented R8 scheduled for daily bathing assistance. Furthermore, CNS-A stated, the caregivers must have documented in error R8's daily bathing assistance, and CNS-A planned to educate the employees on the licensee's documentation policy. The licensee's 2.38 Resident Record -	0 730		

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0 730	Continued From page 18 Information and Content policy dated February 10, 2024, included "[Licensee] will maintain appropriate and accurate records for each resident that is receiving assisted living services." In addition, indicated "Resident Records must include: 11. Documentation that services have been provided as identified in the service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee had a cleared Minnesota Department of Human Services (DHS) NETStudy 2.0 background study for one of two employees;	01290		

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01290	Continued From page 19 unlicensed personnel (ULP-D). This had the potential to affect all residents in the facility. This resulted in an immediate correction order issued on March 4, 2024, at 5:00 p.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D was hired on August 26, 2021, to provide direct care services to residents. On March 4, 2024, during a continuous observation from 12:45 p.m., to 1:15 p.m., ULP-D assisted R1 with personal cares and R2 and R3 with medication administration. ULP-D was unsupervised during the observation of direct cares. ULP-D's record contained a Department of Human Services (DHS) background study (BGS) dated July 13, 2021. The DHS NETStudy 2.0 Roster was reviewed with the licensed assisted living director (LALD)-C on March 4, 2024, at 2:50 p.m. The roster indicated ULP-D's background study was initiated under a COVID-19 waiver, which expired December 31, 2022. LALD-C stated she was unsure why ULP-D was not on the roster and she would let human resources know.	01290		

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01290	Continued From page 20 The MN DHS website Frequently Asked Questions (FAQs) on Background Studies, updated January 23, 2024, indicated emergency studies initiated during the COVID-19 pandemic were no longer valid. The website indicated, "If an individual who is still affiliated has not had a new fingerprint-based background study submitted since their emergency study expired, then your entity is not compliant with state and federal background study requirements. A new fingerprint-based study must be submitted immediately in NETStudy 2.0 for individuals who do not have one." The licensee 4.02 Background Studies policy dated February 10, 2024, indicated no employees would provide direct care services or have independent direct contact with any resident until an acceptable background study had been received. No further information was provided. TIME PERIOD OF CORRECTION: Immediate	01290		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered	01440		

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01440	Continued From page 21 nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for one of two employees (unlicensed personnel (ULP)-D). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired August 26, 2021, to provide direct cares for the licensee's residents. On March 4, 2024, during a continuous observation from 12:45 p.m., to 1:15 p.m., ULP-D assisted R1 with personal cares and R2 and R3 with medication administration. ULP-D stated	01440		

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01440	Continued From page 22 she had in-person training with the RN on medication administration. On March 6, 2024, at 10:20 a.m., clinical nurse supervisor (CNS)-A stated she had done the medication training for ULP-D but was unsure where the documentation was. -at 1:00 p.m., CNS-A stated there was no documentation of 30-day supervision for ULP-D. Manager assistant (MA)-L stated they had contacted the previous owner of the facility and requested missing records for ULP-D but had not received them yet. No documentation of training or 30-day supervision was provided. The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated February 10, 2024, indicated supervision of staff performing delegated tasks would be provided within 30 calendar days of when the individual began working and first performed delegated tasks for residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01470 SS=D	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;	01470		

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01470	Continued From page 23 (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or	01470		

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01470	Continued From page 24 (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff providing services completed an orientation to assisted living facility licensing requirements and regulations before providing services, for one of two staff, unlicensed personnel (ULP)-D. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D was hired August 26, 2021, to provide direct cares for the licensee's residents. On March 4, 2024, at 9:30 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-C stated the licensee was aware of the required contents of employee records. On March 4, 2024, during a continuous observation from 12:45 p.m., to 1:15 p.m., ULP-D assisted R1 with personal cares and R2 and R3 with medication administration.	01470		

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01470	Continued From page 25 ULP-D's employee record lacked documentation the following orientation topics were completed prior to providing assisted living services: - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and - 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. On March 6, 2024, at 1:00 p.m., manager assistant (MA)-L stated they had contacted the previous owner of the facility and requested missing orientation and training records for ULP-D, but they had not received them yet. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, dated February 10, 2024, indicated, "All staff of [licensee] providing and supervising direct services must complete an orientation to Assisted Living facility licensing requirements and regulations before providing assisted living services to residents." The policy further indicated; the following topics would be included: ·Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; and ·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	01470		

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01470	Continued From page 26 Services, county-managed care advocates, or other relevant advocacy services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the	01620		

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01620	Continued From page 27 licensee failed to ensure the registered nurse (RN) completed ongoing comprehensive reassessments using the uniform assessment tool at an interval not to exceed 90 days for three of four residents (R1,R7, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1 was admitted March 3, 2023, with diagnoses including dementia. R1's service plan dated February 15, 2024, indicated R1 received services to include assistance with medication administration and assistance with bathing and dressing. R1's record included a comprehensive nursing assessment dated September 5, 2023, and a subsequent assessment completed January 7, 2024, 124 days after the previous assessment. R7 R7 was admitted April 12, 2018, with diagnoses including dementia, anxiety, and bipolar disorder (a mental illness that causes extreme mood swings). R7's unsigned service plan, dated September 1, 2021, indicated R7 received services to include	01620		

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01620	Continued From page 28 assistance with housekeeping, laundry, meals, safety checks, transfers, dressing, grooming, bathing, toileting, and medication administration. R7's record included a comprehensive nursing assessment dated August 23, 2023, and a subsequent assessment dated January 2, 2024, 133 days after the previous assessment. R10 R10 was admitted August 23, 2023, with diagnoses including dementia. R10's service plan dated February 14, 2024, indicated R10 received services to include assistance with medication administration and assistance with bathing and grooming. R10's record included a comprehensive nursing assessment dated September 5, 2023, and a subsequent assessment dated January 5, 2024, 122 days after the previous assessment. On March 5, 2024, at 12:15 p.m., clinical nurse supervisor (CNS)-A stated the previous nurse had not completed the comprehensive nursing assessments on time for R1, R7, and R10, and the assessments were done late. The licensee 6.01 Assessments, Reviews & Monitoring policy, dated February 10, 2024, indicated "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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	01620		

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01620	Continued From page 29 (21) days	01620		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised, and included a signature or other authentication by the facility and by the resident, or their representative, documenting agreement on the services to be provided for one of four residents (R8). This practice resulted in a level two violation (a	01640		

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01640	Continued From page 30 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R8 was admitted on October 5, 2020, with diagnoses to include dementia, anxiety, and peripheral vascular disease (a progressive circulation disorder). On March 5, 2024, at 7:55 a.m., the surveyor observed ULP-J assist R8 with medication administration. R8's signed service plan dated February 28, 2023, indicated R8 received services to include assistance with housekeeping, meals, toileting, bathing, dressing, grooming, nail care, safety checks, vital sign monitoring, and medication weekly check. R8's service plan, printed March 5, 2024, at 9:31 a.m., during the survey, indicated R8 received the following additional services: assistance with mechanical soft diet with thin liquids, and medication administration. R8's service plan lacked a signature to document agreement with the revisions. On March 6, 2024, at 11:00 a.m., clinical nurse supervisor (CNS)-A stated, she was aware there were revisions made to R8's services provided, and those changes were not authenticated by the facility and the resident or resident's representative. CNS-A further stated she planned	01640		

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01640	Continued From page 31 to work on the service plan process. The licensee's 6.10 Service Plan Modifications policy dated February 10, 2024, included, "When a resident at [Licensee] receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative." The policy additionally indicated, "If the service plan needs to be modified due to a change in a prescriber's order or a change in the resident's needs, the Service Plan Modification form will be completed; this form includes: -Describe changes in service and whether the service is added (new), changed, or discontinued; -Frequency of new service or if service if terminated; -Identification of the staff who will perform the service; -Schedule and methods of monitoring staff; -Fee for the service; -Date/signature of RN making changes; and -Date/signature of resident or the resident's representative each time a modification is made. The signature may be obtained by mail or fax if an agreement was reached in person or by telephone." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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	01760		

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01760	Continued From page 32 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 the steps of the medication administration process were followed for one of four residents (R10). 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: R10's diagnosis included dementia. R10's service plan dated February 14, 2024, indicated the resident received services including assistance with medication administration. R10's prescriber orders dated August 23, 2023, included orders for fluticasone propionate 50	01760		

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01760	Continued From page 33 micrograms/spray (for sinus congestion). On March 5, 2024, at 7:45 a.m., unlicensed personnel (ULP)-F was observed to administer two sprays of fluticasone propionate 50 micrograms into each of R10's nostrils. Without wiping the applicator tip, ULP-F put the cap back on the bottle and placed the nasal spray back into the medication cart. On March 5, 2024, at 8:05 a.m., ULP-F stated she did not wipe the nasal applicator tip prior to putting the cap back on the bottle but should have. On March 6, 2024, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated, "wiping the nose piece is not part of the training and needs to be added." The Mayo Clinic guidelines on fluticasone (nasal route) administration, dated March 1, 2024, indicated the tip of the outside of the nose piece should be with wiped with a clean, dry tissue or cloth before putting the cap back on. The licensee's untitled and undated nasal spray procedure, indicated "wipe the nasal applicator with a clean tissue and replace the dust cover." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in	01890		

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01890	Continued From page 34 the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to discard expired medication for one of four residents (R13). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On March 5, 2024, at 9:30 a.m., the surveyor observed the licensee's medication cart located on the second floor of the facility with unlicensed personnel (ULP)-D. The surveyor observed R13's medication, located in the bottom drawer of the medication cart, with the following information, including beyond use date of the medication: - triamcinolone acetonide (for skin conditions) 0.1 percent (%) ointment, topical, apply a thin layer twice a day as needed to scalp lesion/leg, discard after October 20, 2023. On March 5, 2024, at 9:40 a.m., ULP-D stated, she would bring the expired ointment for R13 to the clinical nurse supervisor (CNS)-A. -9:45 a.m., ULP-D brought R13's expired ointment to CNS-A. CNS-A stated, the licensed	01890		

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01890	Continued From page 35 practical nurses (LPN) checked the medication carts for expired medications every week, and the LPN must have missed R13's expired ointment. The licensee's 7.23 Medication Disposal policy dated February 10, 2024, included "The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and	02170		

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02170	Continued From page 36 included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan contained all required content for four of four residents (R1, R7, R8, R10). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R7, R8, and R10 were admitted to the licensee on March 3, 2022, April 12, 2018, October 5, 2020, and August 23, 2023, respectively, and resided in the licensee's	02170		

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02170	Continued From page 37 secured dementia care facility. R1's diagnoses included Alzheimer's dementia, encephalopathy (a disease that affects the brain structure or function), and atherosclerotic heart disease (narrowing and hardening of the arteries). R7's diagnoses included Alzheimer's dementia, anxiety, and bipolar disorder (a mental illness characterized by extreme mood swings). R8's diagnoses included dementia, anxiety, and peripheral vascular disease (a progressive circulation disorder). R10's diagnoses included dementia, depression, and legal blindness. R1, R7, R8, and R10's medical record included an untitled document which noted "fun facts about me," "activities I may be interested in," and "how to best support me," but lacked an evaluation for activities which included the following: -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate; -identification of activities for behavioral interventions; and -a fully completed individual activity plan. On March 6, 2024, at 11:50 a.m., life enrichment lead (LEL)-M stated, she completed a resident profile for the residents, but was not aware each resident with a dementia diagnosis required an individualized activity plan.	02170		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(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
02170	Continued From page 38 The licensee's 3.05 "ALDC Life Enrichment Programs, Activities & Outdoor Space" policy dated December 1, 2023, included, "3. Each resident must be evaluated for activities of interest according to the licensing rules of the facility and must address the following: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the resident to participate, and -identification of activities for behavioral interventions." Additionally, the policy indicated, "4. An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02310 SS=H	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 39 of one resident (R5) who utilized consumer bed rails, and one of two residents (R4) who utilized hospital style bed rails. This resulted in an immediate correction order issued on March 4, 2024, at 5:00 p.m. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R5 R5 had diagnoses which included vascular dementia, atherosclerotic heart disease, rheumatoid arthritis, and history of a transient ischemic attack (TIA). R5's unsigned Service Plan printed March 4, 2024, indicated R5 was a high fall risk, and required assistance with bathing, laundry, housekeeping, dressing, grooming, toileting, ambulation, and medication administration. On March 4, 2024, at 12:32 p.m., the surveyor observed R5's apartment with unlicensed personnel (ULP)-F. R5 was lying on his left side, with a consumer grab bar on the left side of R5's twin size bed. The consumer grab bar was P-shaped, and included a black vinyl cover that stretched across the opening of the grab bar. R5's medical record included a	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 40 Restraint/Entrapment Assessment dated September 12, 2023, but lacked the following: -manufacturer's guidelines for the Stander 401 Bed Cane; -evidence the licensee referred to the Consumer Product Safety Commission (CSPC) for bed rail recall information. R4 R4 was admitted to licensee on February 5, 2024, and had diagnoses which included encephalopathy, adult failure to thrive, and dementia. R4's unsigned Service Plan dated March 4, 2024, indicated R4 was a high fall risk, and required assistance with safety checks, bathing, laundry, housekeeping, dressing, grooming, toileting, ambulation, and medication administration. On March 4, 2024, at 10:56 a.m., the surveyor observed R4's apartment with ULP-E. R4 was lying supine in the hospital style bed with bilateral upper rails in the upright position. R4's medical record included a Bed Rail Risk Data Collection tool dated February 26, 2024. Included in the section titled, "For Side Rails," zone one, zone two, and zone four were noted as "4.25 max," and zone six was noted as "< (less than) 2," and lacked the following: -exact measurements of the four federal drug administration (FDA) regulated entrapment zones. On March 4, 2024, at 1:18 p.m., clinical nurse supervisor (CNS)-A stated, the licensee did not have the manufacturer's instructions for R5's consumer grab bar, and possibly R5's daughter had the manufacturers instruction document. In	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 41 addition, CNS-A stated, they did not have documentation the recall was checked for the consumer grab bar being utilized by R5. -at 1:48 p.m., CNS-A stated, R4's hospital style bed rail assessment did not include exact measurements of all four FDA regulated entrapment zones. CNS-A also verbalized R4's zone three was not documented and she would complete a reassessment on R4's bed rails. -at 1:50 p.m., CNS-A stated, she was not aware of any other residents at the facility who utilized a consumer grab bar. CNS-A verbalized the remainder of residents at the facility with bed rails, utilized hospital style bed rails. The licensee's 6.28 Side rails policy dated February 10, 2024, included "1. Staff of [Licensee] will determine if the side rail is considered to be safe. "Safe" shall be defined as meeting all of the requirements listed below: a. The side rail is used consistent with manufacturer's directions. Be aware of side rails that slide between the mattress and box spring designed for toddler use; b. The side rails are installed securely and maintained in good operating condition. Be aware of "wobbly" side rails; and c. The side rail design is consistent with the FDA's 2006 recommended dimensional measurements to reduce entrapment. This means side rail zones 1,2, and 3 must not exceed 4.75." The undated Bedcane manufacturer's instructions included "3. IMPORTANT: If the top of the Handle is installed higher than 4 inches or lower than 4 inches, there is a risk of entrapment. Entrapment is a condition where the user of the Bedcane can become trapped between the Bedcane and the bed which could result in injury	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 42 and/or death. Also, never remove Sewn Organizer from handle. The Sewn Organizer also helps prevent entrapment." The Food and Drug Administration's (FDA), A Guide to Bed Safety, dated March 10, 2006, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently Asked Questions (FAQs), last updated February 20, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

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02310	Continued From page 43 - The resident's bed rail use/need assessment: - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for "consumer beds", the licensees should refer to individual manufacturer's guidelines for appropriate installation, maintenance, and use. In addition, licensees should refer to the CSPC for the most up-to-date information related to portable bed side rail recall information. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310		
02350 SS=D	144G.91 Subd. 7 Courteous treatment Residents have the right to be treated with courtesy and respect, and to have the resident's property treated with respect This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of one resident (R10) reviewed, was treated with dignity and respect. This practice resulted in a level two violation (a violation that did not harm a resident's health or	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

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02350	Continued From page 44 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: R6 was admitted on January 10, 2023, with a diagnosis of dementia. A comprehensive nursing assessment, dated January 1, 2024, indicated housekeeping and laundry services were "provided routinely by the community." R10's service plan dated February 14, 2024, indicated the resident received services to include, toileting, bathing, and bed making. On March 5, 2024, at 7:00 a.m., unlicensed personnel (ULP)-F was observed to assist R10 from her bed into the bathroom for morning cares. R10's incontinent brief was observed to be wet. After cares were completed, ULP-F was observed to return to R10's bed to remove the bedding and sheets. ULP-F stated the bed was wet and she would need to "come back later" to take care of the mattress cover. The surveyor observed a large urine stain covering the center of the mattress cover. On March 6, 2024, at 9:38 a.m., ULP-F stated she had not removed the mattress cover from R10's bed and "someone else must have because the bed was made when I got back." -at 10:00 a.m., the surveyor observed the mattress cover with clinical nurse supervisor	02350		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25829	A. BUILDING: _____ B. WING _____	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ALTON	1306 ALTON STREET SAINT PAUL, MN 55116

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02350	Continued From page 45 (CNS)-A. A large, dried urine stain was observed at the center of the mattress protector. CNS-A stated, "I don't think it's being washed," and "I will get staff to wash it." The licensee's 8.13 Pathogen Exposure Control Plan dated February 10, 2024, defined contaminated laundry as "laundry which has been soiled with blood or other potentially infectious materials." The policy indicated "communities will maintain a clean and sanitary environment, and further indicated contaminated laundry would be washed as soon as possible. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02350		

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Full
Date: *03/06/24*
Time: 15:17:22
Report: 1023241043

Food and Beverage Establishment Inspection Report

Location:
The Alton Memory Care
1306 Alton Street
St Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: 0037832
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516992480
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ***** Priority 2 *****

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

HIGH TEMP DISH MACHINE IN USE BUT NO IRREVERSIBLE DEVICE PRESENT. ACQUIRE AND USE THIS DEVICE TO ENSURE PATHOGEN ELIMINATION.

Comply By: 03/06/24

4-600 Cleaning Equipment and Utensils

4-601.11A ***** Priority 2 *****

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

FOOD DEBRIS CRUSTED ON CAN OPENER BLADE. CLEAN AFTER USE AND STORE CLEAN.

Comply By: 03/06/24

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED FOOD DEBRIS SUCH AS BACON IN HAND SINK.

Comply By: 03/06/24

2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

NO CERTIFICATE POSTED.

Comply By: 03/06/24

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REACH IN COOLER ON THIRD FLOOR DOMESTIC GRADE.

Comply By: 03/06/24

4-500 Equipment Maintenance and Operation

4-501.11AB

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

VENTILATION HOOD MISSING LIGHT BULBS AND BULB COVERS.

Comply By: 03/06/24

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

CUTTING BOARDS SCORED AND DISCOLORED. REPAIR/REPLACE CUTTING BOARDS AND KEEP IN GOOD CONDITION.

Comply By: 03/06/24

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

BACK HAND SINK CLOGGED SO THAT WATER DOES NOT DRAIN. REMOVE COFFEE WATER LINE FROM SECOND FLOOR AREA SO THAT IT DOESN'T BLOCK SINK.

Comply By: 03/06/24

Surface and Equipment Sanitizers

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: 3 COMP SINK
Violation Issued: No

Hot Water: = at 171 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Type: Full
Date: *03/06/24*
Time: 15:17:22
Report: 1023241043
The Alton Memory Care

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: Cold Hold/CUT MELON
Temperature: 39 Degrees Fahrenheit - Location: WALK IN COOLER
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 40 Degrees Fahrenheit - Location: REACH IN COOLER
Violation Issued: No

Process/Item: Cold Hold/BACON
Temperature: 41 Degrees Fahrenheit - Location: PREP COOLER
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 2ND FLOOR
Violation Issued: No

Process/Item: Cold Hold/JUICE
Temperature: 40 Degrees Fahrenheit - Location: PREP COOLER 2ND FLOOR
Violation Issued: No

Process/Item: Cold Hold/YOGURT
Temperature: 41 Degrees Fahrenheit - Location: REACH IN COOLER 3RD FLOOR
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	0	3	5

THIS INSPECTION WAS CONDUCTED IN CONJUNCTION WITH MDH HEALTH REGULATORY DIVISION (HRD) SURVEY. INSPECTION CONDUCTED IN PRESENCE OF THE PERSON IN CHARGE.

THIS FACILITY HAS COMMERCIAL EQUIPMENT IN THE MAIN KITCHEN ON THE FIRST FLOOR, A SATELLITE KITCHEN ON THE SECOND FLOOR, AND A SERVING AREA ON THE THIRD FLOOR. FOOD SERVICE IS PROVIDED BY CARE FACILITY STAFF.

THESE TOPICS WERE DISCUSSED WITH THE PERSON IN CHARGE:
- EMPLOYEE ILLNESS EXCLUSION
- HAND WASHING PROCEDURE
- NO BARE HAND CONTACT WITH RTE FOOD
- FOOD COOLING METHODS
- FOOD REHEATING METHODS
- VOMIT CLEAN UP PROCEDURE
- FULLY COOKING FOOD FOR HIGH RISK POPULATIONS
- PASTEURIZED SHELL EGGS

*SERVICE GREASE TRAP REGULARLY

*HAVE HOOD PROFESSIONALLY CLEANED REGULARLY

*REMOVE UNUSED EQUIPMENT

Type: Full
Date: *03/06/24*
Time: 15:17:22
Report: 1023241043
The Alton Memory Care

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1023241043 of 03/06/24.

Certified Food Protection Manager: BRANDY CAMPBELL

Certification Number: 95131 Expires: 07/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
BRANDY CAMPBELL
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us

Minnesota Department of Health
Division of Environmental Health, FPLS
PO Box 64975
Saint Paul, 55164-0975
651-201-4500

Type: Follow-Up
Date: *03/08/24*
Time: 14:56:39
Report: 1023241048

Food and Beverage Establishment Inspection Report

Location:
The Alton Memory Care
1306 Alton Street
St Paul, MN55116
Ramsey County, 62

Establishment Info:
ID #: 0037832
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6516992480
ID #:

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

The following orders previously issued on 03/06/24 have NOT been corrected.

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ***** Priority 2 *****

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED FOOD DEBRIS SUCH AS BACON IN HAND SINK.

Issued on: 03/06/24 *Comply By: 03/06/24*

4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

REACH IN COOLER ON THIRD FLOOR DOMESTIC GRADE.

Issued on: 03/06/24 *Comply By: 03/06/24*

4-500 Equipment Maintenance and Operation

4-501.12

MN Rule 4626.0740 Resurface scratched or scored cutting blocks and boards or discard if they can no longer be effectively cleaned and sanitized or resurfaced.

CUTTING BOARDS SCORED AND DISCOLORED. REPAIR/REPLACE CUTTING BOARDS AND KEEP IN GOOD CONDITION.

Issued on: 03/06/24 *Comply By: 03/06/24*

Type: Follow-Up
Date: *03/08/24*
Time: 14:56:39
Report: 1023241048
The Alton Memory Care

Food and Beverage Establishment Inspection Report

5-200A Plumbing: approved materials/design

5-201.11B

MN Rule 4626.1040B Maintain the plumbing system in good repair.

BACK HAND SINK CLOGGED SO THAT WATER DOES NOT DRAIN. REMOVE COFFEE WATER LINE FROM SECOND FLOOR AREA SO THAT IT DOESN'T BLOCK SINK.

Issued on: 03/06/24 *Comply By: 03/06/24*

No NEW orders were issued during this inspection.

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

FOLLOW UP INSPECTION CONDUCTED TO ENSURE SAFE FOOD OPERATION.

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 1023241048 of 03/08/24.

Certified Food Protection Manager: BRANDY CAMPBELL

Certification Number: 95131 Expires: 07/21/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
BRANDY CAMPBELL
PERSON IN CHARGE

Signed: Gregory T Nelson
Gregory T. Nelson
Public Health Sanitarian
Freeman Building
651-201-4259
greg.nelson@state.mn.us