Electronically Delivered

August 28, 2026

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

RE: Project Number(s) SL25977016

Dear Licensee:

On June 2, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on March 17, 2026. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: Stephanie.Jones.de.Palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

HHH

Electronically Delivered

April 7, 2026

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

RE: Project Number(s) SL25977016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 17, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0340 - 144g.30 Subd. 5 - Correction Orders - $500.00
St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

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

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

The correction order documentation should include the following:

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

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

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

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

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

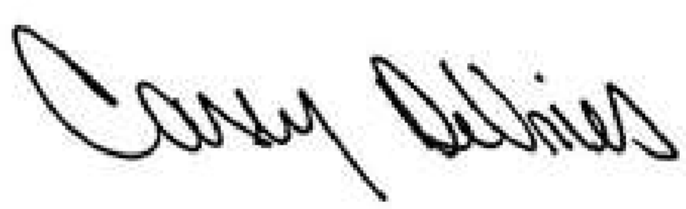
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/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,



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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25977	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL25977016-0 On March 16, 2026, through March 17, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute a plan of correction (POC) for correction orders related to 144G.41 Subd. 3. Infection control program and 144G.70 Subd. 2. (c-f) for initial reviews, assessments, and monitoring, which were both issued following their previous routine survey conducted November 13, 2023, through November 15, 2023. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 340		

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0 340	Continued From page 2 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee received their correction orders via electronic delivery on December 28, 2023, following their November 13, 2023, through November 15, 2023, survey. The longest time-period for correction on the correction orders from the date of receipt was 21-days. MN Statute 144G.30 Subd. 5 (c) (1) indicates by the correction order date; the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon complaint investigation, and as otherwise needed. On March 16-17, 2026, the Minnesota Department of Health (MDH) conducted a routine survey and re-issued correction orders for infection control and initial reviews, assessments, and monitoring of residents. On March 17, 2026, at 12:10 p.m., 12:12 p.m., and 12:20 p.m., licensed assisted living director (LALD)-D provided the surveyor with hundreds of pages of documents in two three-ring binders stating they thought their POC may be found within its pages. The surveyor reviewed the documents with LALD-D; no POC could be located. On March 17, 2026, at 12:25 p.m., LALD-D stated	0 340		

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0 340	Continued From page 3 they must not have completed a POC from the previous survey. LALD-D stated they would make sure to do a POC for next time. LALD-D inquired what should be included in the POC. The surveyor explained POC expectations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the	0 470		

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0 470	Continued From page 4 appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a staffing plan that contained required content and failed to ensure it was updated twice per year. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Staffing Plan dated September 29, 2025, lacked evidence of the following required information: - staffing metrics to determine appropriate staffing levels; - evidence it had been reviewed twice per year; and - identify the number of staff currently needed to take care of their residents. On March 16, 2026, at 10:46 a.m., during the entrance conference, clinical nurse supervisor (CNS)-A stated they just learned about staffing plans at one of their other surveys at a sister facility. CNS-A asked the surveyor to, "refresh my memory." The surveyor explained what a staffing plan was; CNS-A stated they developed it with the assistance of unlicensed personnel (ULP)-B.	0 470		

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0 470	Continued From page 5 On March 17, 2026, at 12:36 p.m., CNS-A stated they would review the regulation to create a staffing plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not	0 480		

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0 480	Continued From page 6 contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when	0 480		

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0 480	Continued From page 7 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: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 17, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee on March 17, 2026. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced	0 485		

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0 485	Continued From page 8 by: Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On March 16, 2026, at 9:58 a.m., the surveyor observed no menu was posted in the facility. Unlicensed personnel (ULP)-B stated a menu was not posted in the facility. On March 16, 2026, at 10:14 a.m., R2 stated they had never been provided with a menu and had never seen one posted in the facility. R2 stated they (staff) asked him what he wanted, and they would make the food. R2 stated sometimes they bought their own meals. On March 17, 2026, at 12:36 p.m., licensed assisted living director (LALD)-D stated they did have a menu but didn't know what happened to it. LALD-D stated they were aware of the requirement. The licensee's Meal and Menu Requirements policy, undated, indicated, "Menus are prepared at least one week in advance and made available to all residents." No further information was provided.	0 485		

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0 485	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=F	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: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care or medical and nursing standards for infection control related to hand hygiene. The deficient practice had the potential to affect all residents, employees, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to	0 510		

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0 510	Continued From page 10 affect a large portion or all of the residents). The findings include: The facility was a rambler style home with a main floor bathroom and basement bathroom. On March 16, 2026, at 9:41 a.m., unlicensed personnel (ULP)-B requested the surveyor wash their hands upon entry to the facility. The surveyor observed the main floor bathroom which lacked soap for hand washing and paper towels for hand drying. The surveyor observed a paper towel dispenser mounted on the wall which was empty. ULP-B obtained a bottle of liquid hand soap for the surveyor but did not provide paper towels for hand drying. When the surveyor exited the bathroom, ULP-B provided a paper towel for hand drying. On March 16, 2026, at 12:39 p.m., the surveyor observed the main floor bathroom lacked paper towels for hand drying. On March 17, 2026, at 8:04 a.m., the surveyor observed the main floor bathroom lacked paper hand towels for hand drying. On March 17, 2026, at 12:16 p.m., the surveyor observed the main floor bathroom lacked paper hand towels for hand drying. On March 17, 2026, at 12:36 p.m., clinical nurse supervisor (CNS)-A, licensed assisted living director (LALD)-D, and ULP-B stated they should always have paper towels for hand drying in the bathrooms. ULP-B stated the main floor bathroom did have towels in it. The surveyor explained they observed the main floor bathroom four times in two days and never once observed	0 510		

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	25977	A. BUILDING: _____ B. WING _____	03/17/2026

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STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

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0 510	Continued From page 11 paper towels. The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers webpage, last updated on February 27, 2024, indicated: "Know how to wash hands with soap and water 1. Wet hands with water. 2. Apply the manufacturer recommended amount of product to your hands. 3. Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. 4. Rinse hands with water and use disposable towels to dry. Use a towel to turn off the faucet. 5. Avoid using hot water to prevent drying of the skin." The licensee's Hand Hygiene and Handwashing policy, undated, indicated: "Handwashing Procedure (Soap & Water) Staff must follow these steps: 1. Wet hands with clean, running water 2. Apply soap 3. Lather all surfaces (backs of hands, between fingers, under nails) 4. Scrub for at least 20 seconds 5. Rinse thoroughly under running water 6. Dry with a clean paper towel 7. Use towel to tum off faucet." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment	0 550		

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0 550	Continued From page 12 All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post information directing individuals to the Office of Health Facility Complaints (OHFC) at the Minnesota Department of Health (MDH) if they had complaints about the facility or person providing services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 16, 2026, at 9:58 a.m., the surveyor	0 550		

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0 550	Continued From page 13 observed the licensee's postings which lacked information directing individuals to OHFC if they had complaints about the facility or person providing services. On March 17, 2026, at 12:36 p.m., clinical nurse supervisor (CNS)-A stated there was no OHFC posting. Licensed assisted living director (LALD)-D stated they thought the OHFC information was included along with their grievance posting. The licensee's Required Postings policy, undated, indicated, "All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have 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 and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:	0 640		

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0 640	Continued From page 14 (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the 911 emergency phone number near the facility house phone. This had the potential to affect all residents, staff, and visitors at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On March 17, 2026, at 8:00 a.m., the surveyor observed a cordless black Panasonic house phone on its charging docking station in the kitchen on the counter top. The surveyor observed 911 was not posted anywhere in the kitchen space. Unlicensed personnel (ULP)-C stated the house phone was for use by both staff and residents. On March 17, 2026, at 12:36 p.m., ULP-B stated	0 640		

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0 640	Continued From page 15 they did have 911 posted in the living room. The surveyor explained 911 was posted in a completely different room and needed to be posted near all house phones. Licensed assisted living director (LALD)-D and ULP-B stated they thought 911 was posted near the house phone and would get it posted immediately. The licensee's Required Postings policy, undated, indicated: "The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
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;	0 680		

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0 680	Continued From page 16 (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 interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content for staff, residents, and visitors to view. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 17, 2026, at 9:00 a.m., the surveyor reviewed the licensee's Emergency Preparedness Manual, last reviewed by the licensee on June 1, 2024. The EPP lacked the	0 680		

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0 680	Continued From page 17 following required content: - reviewed/updated annually; - all-hazards risk assessment; - missing resident policy review every three months (last documented date of review May 5, 2022); - includes policies/procedures (P/P) for at minimum food, water, and pharmaceutical supplies; - qualified person who is authorized in writing to act in the absence of the administrator; - communication plan must include all the following names/contact information: staff, entities providing services under agreement, residents' physicians, other facilities, volunteers; - P/P must address: use of volunteers, including the process/role for integration; - training program must include all of the following: - initial training in EP P/P to all new and existing staff, individuals providing services under arrangement, and volunteers consistent with their expected role - provide EP training at least annually - maintain documentation of all EP training - demonstrate staff knowledge of EP; and -documentation of conducted exercises to test the EP at least twice per year, including unannounced staff drills using the EPP. On March 17, 2026, at 11:47 a.m., licensed assisted living director (LALD)-D stated their EPP should have been reviewed or updated in June 2025, and they were aware of the requirement. LALD-D stated they had not been reviewing their missing resident policy quarterly and were not aware it was a requirement. LALD-D stated they did not have an all-hazards assessment completed but were aware of what it was and its requirements. LALD-D stated they had a backup	0 680		

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0 680	Continued From page 18 supply of food, water, and medical supplies on hand, but their EPP did not identify the quantity needed to sustain their population in the event of an emergency. LALD-D stated they completed staff training and facility drills but did not have the documentation to add to EPP binder. LALD-D stated drills and staff training programs were completed but the documentation was not in the EPP. LALD-D stated they did not know a qualified person was required to be authorized in writing to act in the absence of the administrator. LALD-D stated they hired a consultant who was still working on their EPP with them and helping them update it into compliance. The licensee's Emergency Preparedness policy dated May 5, 2022, indicated, "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. Stanton House With Services will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775		

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0 775	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for	0 780		

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0 780	Continued From page 20 sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 21 The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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	0 790		

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0 790	Continued From page 22 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 800		

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0 800	Continued From page 23 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.	0 810		

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0 810	Continued From page 24 (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm? to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25977	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 25 Environment Inspection Report (PEIR) dated Mach 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the	0 900		

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0 900	Continued From page 26 facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a written contract on or before the date of admission with the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: The licensee's Current Resident Roster dated March 16, 2026, indicated R2 was admitted to the licensee on November 24, 2025. R2's Resident Notes dated December 1, 2025, at 10:04 p.m., indicated R2 arrived at the facility on December 1, 2025. R2's Service Plan dated December 9, 2025, indicated R2 received services for medication administration, bathing reminders, dressing, behavior management, and housekeeping. The service plan further indicated R2's intake date was December 1, 2025. R2's Assisted Living Contract was signed and dated by R2 on December 4, 2025.	0 900		

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0 900	Continued From page 27 On March 16, 2026, at 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R2. On March 17, 2026, at 10:55 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated R2 was admitted to the licensee on December 1, 2025. The surveyor observed CNS-A reviewing R2's notes and stated R2 arrived at 6:00 p.m. LALD-D and CNS-A did not have an explanation why the contract was completed late, but stated they were aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;	01060		

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01060	Continued From page 28 (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation greater than four days for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01060		

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01060	Continued From page 29 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R4 was admitted to the licensee on June 24, 2025. R4's diagnoses included sickle cell anemia. R4's Service Plan (Waiver) - Addendum to Contract signed March 16, 2026, indicated R4 received medication administration, dressing assistance, behavior management, and vital sign monitoring. R4's Resident Notes dated March 12, 2026, at 10:45 p.m., indicated on March 12, 2026, at approximately 3:30 p.m., R4 was found lying on the floor and extremely drowsy; 911 was called and R4 was taken to Hennepin County Medical Center (HCMC) by ambulance. R4's Resident Notes dated March 14, 2026, at 10:41 a.m., indicated R4 continued to be inpatient at HCMC for pain management due to their sickle cell anemia. R4's Resident Notes dated March 16, 2026, at 10:26 p.m., indicated R4 returned to the facility from HCMC on March 16, 2026, at approximately 6:00 p.m. R4's record lacked an emergency relocation form and documentation the ombudsman had been	01060		

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01060	Continued From page 30 contacted. On March 16, 2026, at 1:50 p.m., licensed assisted living director (LALD)-D's email indicated they were seeking clarification as to what was meant by emergency relocation. On March 16, 2026, at 3:26 p.m., LALD-D 's email indicated R4 never had an emergency relocation. On March 17, 2026, at 8:02 a.m., the surveyor observed R4 in the facility. R4 stated they returned to the facility on March 16, 2026, in the evening. R4 stated they were in the hospital for a few days for their sickle cell anemia. On March 17, 2026, at 8:40 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R4. On March 17, 2026, at 8:44 a.m., LALD-D stated they were not sure what the surveyor meant by an emergency relocation form. The surveyor explained the emergency relocation requirements. On March 17, 2026, at 8:49 a.m., LALD-D stated they did not have a blank copy of an emergency relocation form to provide. LALD-D stated they did not provide any emergency relocation information to R4 and did not contact OOLTC as they did not know it was a requirement. The licensee's Assisted Living Contract Terminations policy, undated, indicated: "1. A facility may remove a resident from the facility in an emergency, if necessary, due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of	01060		

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01060	Continued From page 31 another facility resident or facility staff member. An emergency relocation is NOT a termination. 2. In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: a. The reason for the relocation b. The name and contact information for the location to which the resident has been relocated and any new service provider c. Contact information for the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01610 SS=F	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.	01610		

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01610	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an initial comprehensive nursing assessment on, or before, the date of admission for two of two residents (R2, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R2 R2's Resident Notes dated December 1, 2025, at 10:04 p.m., indicated R2 arrived at the facility on December 1, 2025. R2's Service Plan dated December 9, 2025, indicated R2 received services for medication administration, bathing reminders, dressing, behavior management and housekeeping. The service plan further indicated R2's intake date was December 1, 2025. R2's Admission Assessment was completed on December 5, 2025, four days after R2's date of admission to the facility. R4 R4 was admitted to the licensee on June 24, 2025.	01610		

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01610	Continued From page 33 R4's Service Plan dated March 16, 2026, indicated R4 received services for medication administration, behavior management, housekeeping, dressing, and bathing reminders. R4's Admission Assessment was completed on June 28, 2025, four days after R4's date of admission to the facility. On March 16, 2026, at 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R2. On March 17, 2026, at 8:40 a.m., the surveyor observed ULP-C administer medication for R4. On March 17, 2026, at 10:55 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated R2 was admitted to the licensee on December 1, 2025. LALD-D and CNS-A stated R2's admission assessment was completed late. On March 17, 2026, at 11:23 a.m., CNS-A stated R4's admission assessment was completed late after R4's date of admission. CNS-A stated they had still been learning as they went through more surveys about resident assessment schedules. CNS-A requested the surveyor show them where in the regulations it indicated admission assessments were due on or before the date of admission. CNS-A handed the surveyor their Home Care & Assisted Living Laws & Rules book which had page markers to mark pages for CNS-A's reference. The pages marked by CNS-A were for the 144A home care regulations, not the 144G assisted living regulations. The surveyor explained to CNS-A they had page marked the incorrect regulations. CNS-A stated they believed	01610		

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01610	Continued From page 34 they had a five-day grace period to complete admission assessments and stated they had been referencing the wrong regulations in their regulation book. The licensee's Nursing Assessment and Reassessment of Residents policy, undated, indicated, "The facility will conduct a nursing assessment prior to, the date on which a resident executes a contract with a facility or the day the resident moves in, whichever is earlier." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01610		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must	01620		

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01620	Continued From page 35 be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted a comprehensive assessment within 14 days after admission for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01620		

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01620	Continued From page 36 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's Resident Notes dated December 1, 2025, at 10:04 p.m., indicated R2 arrived at the facility on December 1, 2025. R2's Service Plan dated December 9, 2025, indicated R2 received services for medication administration, bathing reminders, dressing, behavior management, and housekeeping. The service plan further indicated R2's intake date was December 1, 2025. R2's Admission Assessment was completed on December 5, 2025, four days after R2's date of admission to the facility. R2's next assessment was not completed until January 25, 2026, 51 days after the admission assessment. On March 16, 2026, at 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R2. On March 17, 2026, at 10:55 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A stated R2 was admitted to the licensee on December 1, 2025. CNS-A stated the 14-day assessment was not completed. CNS-A stated they should have completed it when they saw R2 next on December 6, 2025. CNS-A stated they were aware of the 14-day assessment requirement.	01620		

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01620	Continued From page 37 The licensee's Nursing Assessment and Reassessment of Residents policy, undated, indicated, "Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiating services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01630 SS=F	144G.70 Subd. 3 Temporary service plan When a facility initiates services and the individualized assessment required in subdivision 2 has not been completed, the facility must complete a temporary plan and agreement with the resident for services. A temporary service plan shall not be effective for more than 72 hours. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to complete a temporary service plan as required at the time of admission for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01630		

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STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01630	Continued From page 38 R2's Resident Notes dated December 1, 2025, at 10:04 p.m., indicated R2 arrived at the facility on December 1, 2025. R2's Service Plan dated December 9, 2025, indicated R2 received services for medication administration, bathing reminders, dressing, behavior management and housekeeping. R2's Contract signed on December 4, 2025, included a Service Plan signed on December 4, 2025; it was completed four days after R2's admission. On March 16, 2026, at 12:01 p.m., the surveyor observed unlicensed personnel (ULP)-B administer medication for R2. On March 17, 2026, at 12:36 p.m., clinical nurse supervisor (CNS)-A stated R2's service plan was not initiated until the contract was executed on December 4, 2025. CNS-A stated they had been confusing 144G assisted living regulations with 144A regulations for home care in their Home Care & Assisted Living Laws & Rules book. CNS-A stated they thought they had five days leeway to complete a resident's admission and service plan. The licensee's Service Plan policy, undated, indicated, "When services are initiated for a new resident prior to completion of the individualized resident assessment, a temporary service plan will be developed. A temporary service plan will not be effective for more than 72 hours. A Service Plan shall be finalized with each resident no later than 14 calendar days after the start of service." No further information was provided.	01630		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25977	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01630	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01630		
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 revise and obtain a resident or resident representative's signature documenting a change of services to be provided for one of two residents (R1). This practice resulted in a level two violation (a	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25977	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 40 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R2's Resident Notes progress note dated December 1, 2025, at 10:04 p.m., indicated R2 arrived at the facility on December 1, 2025. R2's Service Plan dated December 9, 2025, indicated R2 received services for medication administration, bathing reminders, dressing, behavior management, and housekeeping. R2's Service Plan printed and signed during the survey on March 16, 2026, indicated R2 received additional services not found on the signed December 9, 2025, including activity assistance and behavior management for hoarding, other mental health needs, and physical aggression. On March 17, 2026, at 12:36 p.m., clinical nurse supervisor (CNS)-A stated there were changes made to R2's services and they forgot to get a new service plan signed by R2 when the changes were made. The licensee's Service Plan policy, undated, indicated, "The service plan and any revisions must include a signature or other authentication by the assisted living provider and by the resident or resident's representative documenting agreement on the services to be provided."	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25977	A. BUILDING: _____ B. WING _____	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON HOUSE WITH SERVICES	3354 JAMES AVENUE NORTH MINNEAPOLIS, MN 55412

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 41 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		

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

Food & Beverage Inspection Report

Establishment Info

STANTON HOUSE WITH SERVICES
3354 JAMES AVENUE NORTH
Minneapolis, MN 55412
Hennepin County
Parcel:

Phone:

License Info

License: HFID 25977

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

Inspection Info

Report Number: F1039261075
Inspection Type: Full - Single
Date: 3/17/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery: Emailed

New Order: 2-100 Supervision

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

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

COMMENT: REISSUE FROM PREVIOUS INSPECTION. NO CFPM IS CURRENTLY EMPLOYED. PERSON-IN-CHARGES STATES THEY WILL PURSUE CFPM CERTIFICATION. GUIDANCE ON SUBJECT SENT WITH THIS REPORT.

Comply By: 6/17/2026 Originally Issued On: 3/17/2026

New Order: 4-200 Equipment Design and Construction

4-204.112A *Priority Level: Priority 3 CFP#: 36*

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

COMMENT: NO AMBIENT DISPLAY THERMOMETER IS PRESENT IN BASEMENT REFRIGERATOR. COMPLY WITH ABOVE RULE.

Comply By: 3/27/2026 Originally Issued On: 3/17/2026

New Order: 4-300 Equipment Numbers and Capacities

4-301.12A *Priority Level: Priority 2 CFP#: 48*

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

COMMENT: ESTABLISHMENT HAS 2-COMPARTMENT SINK ONLY, NO DISHWASHING MACHINE. STAFF ARE USING BUCKET WITH BLEACH SOLUTION TO SANITIZE WARES AFTER WASHING. ESTABLISHMENT MUST INSTALL A DISHWASHING MACHINE OR UPGRADE TO A 3-COMPARTMENT SINK.

Comply By: 6/17/2026 Originally Issued On: 3/17/2026

New Order: 4-500 Equipment Maintenance and Operation

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

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

COMMENT: OVEN/COOKING RANGE ARE NON-FUNCTIONAL. PERSON-IN-CHARGE STATES THIS EQUIPMENT IS SLATED FOR REPLACEMENT.

Comply By: 3/27/2026 Originally Issued On: 3/17/2026

Food & Beverage General Comment

BUTTER - COLD HOLD, KITCHEN REFRIGERATOR - 40 DEGREES F

PACKAGE/DELI MEAT - COLD HOLD, BASEMENT REFRIGERATOR - 40 DEGREES F
FREEZERS - FROZEN

This inspection was completed as part of MDH HRD assisted living facility survey. The inspection was conducted with the person-in-charge and reviewed with MDH HRD nurse evaluator Joey Keen.

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

Present are basement dry food stores, basement refrigerator and chest freezers.

The kitchen has wood cabinets with hollow base and laminate countertops, wood floor, painted walls and ceiling. These kitchen finishes and surfaces are in good repair, clean and well maintained.

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

Verified hand sink correctly set-up, gloves, illness policy, probe thermometer, Chlorine test strips.

Discussed the following with the person-in-charge: food source, foodborne illness symptoms and exclusion of ill employees, avoiding bare hand contact with ready to eat foods, handwashing, sanitizing, all orders on this report.

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

I acknowledge receipt of the Metro District Office inspection report number F1039261075 from 3/17/2026

Terra Ross
person-in-charge

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us

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

Sanitizer Observations/Recordings

Establishment Info

STANTON HOUSE WITH SERVICES
Minneapolis
County/Group: Hennepin County

Inspection Info

Report Number: F1039261075
Inspection Type: Full
Date: 3/17/2026
Time: 11:00 AM

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** bucket at sink
Location: Equal To 100 PPM
Comment: used in lieu of dishwashing machine or sanitizing compartment in 3-compartment sink
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL25977016	**Date:** 3/17/2026
Facility Name: Stanton House with Services	
Facility Address: 3354 James Ave N., Minneapolis, MN 55412	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: A cigarette butt was located on the wooden ramp leading to the side door of the facility. Improperly discarded cigarettes pose a fire risk, and the licensee should ensure all smoking materials are properly discarded in approved receptacles.

3. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. Relocatable power taps (power strips) shall be directly connected to a permanently installed receptacle. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4.2, MSFC 604.4]

   Comments:

   Several unapproved multiplug adapters were in use and were connected in sequence in resident room 1 to power a television and a small fan. Improper use of multiplug adapters may result in risk of a fire. The unapproved multiplug adapters should be removed and any properly listed power strips should be connected directly to the wall outlet.

   An unapproved multiplug adapter was in use in resident room 3 to power several electronics. The unapproved multiplug adapter should be removed.

   Several unapproved multiplug adapters were in use and were connected in sequence in the basement laundry room to power several chest freezers. Improper use of multiplug adapters may result in risk of a

fire. The unapproved multiplug adapters should be removed and any properly listed power strips should be connected directly to the wall outlet.

Several unapproved multiplug adapters were in use and were connected in sequence the basement office to power space heaters and several other electronics. Improper use of multiplug adapters may result in risk of a fire. The unapproved multiplug adapters should be removed and any properly listed power strips should be connected directly to the wall outlet. Portable, electric space heaters should not be plugged into extension cords.

4. A minimum of 18 inches (457 mm) shall be maintained between gas or fueloil heat-producing appliances and combustible materials. [Minn. Stat. 144G.45 subd. 2; MSFC 603.5.3.1]

   Comments: There was a large quantity of combustible material stored against the facility's heater and water heater in the basement of the facility. Boxes of documents, plastic holiday decorations, binders, wrapping paper, signs and other assorted combustible items were stored resting against and directly next to heating equipment. 18 inches of clearance should be obtained and maintained around heating equipment to avoid fire hazard.

5. *Clothes dryers and their exhaust systems shall be cleaned as necessary to keep lint traps, exhaust ducts, and mechanical and heating components free from excessive lint accumulation. [Minn. Stat. 144G.45 subd. 2; MSFC 304.4]*

   Comments: The ventilation plumbing for the clothing dryer was not properly connected and a significant amount of lint had accumulated behind the appliance and in the rafters of the basement laundry room. The lint should be removed, and the ventilation should be properly secured and maintained to avoid accumulation of lint.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarms provided throughout the facility were not properly interconnected. The licensee tested smoke alarms by activating alarms and only a small portion successfully sounded during the tests. Smoke alarms should be interconnected such that the activation of any alarm causes all other alarms in the facility to sound. The smoke alarms installed in the basement office and in resident room

3 were actively chirping during the survey, which indicated that they likely had low battery and were not operating properly, and thus were not maintained in proper condition.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   Comments: A small 5-B:C fire extinguisher was installed in the living room which had a manufacture date in 2019. This extinguisher did not have any annual service tags or documentation of servicing, nor was documentation provided of monthly staff inspection. Extinguishers should be serviced by a licensed contractor at least once a year and must be visually inspected by facility staff at least once a month to ensure proper condition and operability.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments:

   The stove in the kitchen had tags from the utility provider indicating that it was unsafe for operation and that the appliance had been disabled. The kitchen stove was nonfunctional and disconnected from gas and power. The disabled stove appliance should be repaired and inspected before use or replaced in an approved manner to provide safe cooking facilities for the facility.

   The electrical outlet in the living room was discolored and damaged. Electrical fixtures should be maintained in good shape free of damage.

   The electrical outlet in resident room 3 was discolored and damaged. Electrical fixtures should be maintained in good shape free of damage.

The clothing dresser in resident room 1 was significantly damaged with several dresser drawers missing and scratches and damage prominent over the surface of the dresser.

The door frame to resident room 1 was damaged with gaps in the frame. The door frame should be repaired and maintained in good condition.

The outlet cover in the upper-level hallway did not adequately cover electric components of the fixture and was also very loosely connected to the wall with two screws missing. The proper cover should be provided to the electrical outlet, and it should be maintained securely attached to the wall and in good condition.

The tile ceiling in the basement hallway was damaged and sagging with evidence of water damage. The ceiling should be repaired or replaced and maintained in good condition.

The garage showed damage to the soffit and walls with visible holes and missing pieces of siding. The garage should be maintained in a structurally sound condition, free of holes to prevent the intrusion of pests.

The fence was damaged near the side door to the facility with broken wood and nails exposed. The fence should be repaired and maintained in good condition.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: No employee actions for fires or similar emergencies were provided to the surveyor during the survey. No documented employee procedures were located in the fire safety and evacuation plan (FSEP). General fire safety information was provided, but it was not site specific and was not complete. The FSEP should include site-specific procedures for evacuation during fire or similar emergencies.

2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

   Comments: No resident procedures for fires or similar emergencies were provided to the surveyor during the survey. No documented resident procedures were located in the fire safety and evacuation

plan (FSEP). Residents should be provided with site-specific procedures for evacuation during fire or similar emergencies.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: No documentation of unique residents' needs for evacuation was provided to the surveyor during the survey. No documented resident evacuation procedures were located in the fire safety and evacuation plan (FSEP). Unique resident needs should be documented, and records should be maintained so that they are current and accurate so they may be used in the event of an emergency.

4. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

   Comments: No documentation of staff training on the FSEP was provided to the surveyor during the survey. Licensee indicated that the facility was initiating a new online training program through a third-party program but had not begun the trainings yet. Staff should receive site specific training on the FSEP upon hire and twice a year thereafter.

5. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   Comments: No documentation of resident training on the FSEP was provided to the surveyor during the survey. The licensee indicated that residents were informed of fire safety information at admittance but that no records of such training were kept. Residents should be offered training on procedures for evacuation at least once per year.

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

   Comments: Fire drill records provided to the surveyor indicated that fire drills did not occur at least once per shift per year. All documented fire drills in the past year occurred between 8 a.m. and 4:30 p.m. Facility staff indicated that those times did not include fire drills for the overnight shift. No documentation was provided that indicated that drills were conducted during the overnight shift. Fire drills should be provided at least every other month and at least twice per shift per year.