Electronically Delivered

June 6, 2024

Licensee
Hayden Grove of St. Anthony
2601 Stinson Parkway
St Anthony, MN  55418

RE:  Project Number(s) SL39425015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license with dementia care.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on May 15, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

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

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

**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**
Per 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 residents/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 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 calendar days of the correction order receipt date.

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

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

**REQUESTING A HEARING**
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in

writing and received by MDH 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**.

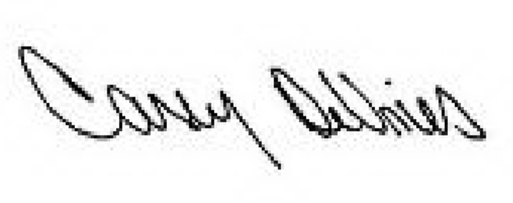
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms 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 |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HAYDEN GROVE OF ST ANTHONY | 2601 STINSON PARKWAY ST ANTHONY, MN 55418 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL39425015-0<br><br>On, May 13, 2024, to May 15, 2024, the Minnesota Department of Health conducted a provisional survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 110 residents, 32 of which were receiving services under the Provisional Assisted Living with Dementia Care license. | 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(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 1<br><br>complies with accepted health care, medical, and nursing standards for infection control.<br>(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.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors.<br><br>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).<br><br>The findings include:<br><br>UNLICENSED PERSONNEL (ULP)-C<br>ULP-C was hired on March 27, 2023, to provide direct care services for residents.<br><br>ULP-E<br>ULP-E was hired on March 1, 2024, to provide | 0 510 | | |

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| 0 510 | Continued From page 2<br>direct care services for residents.<br><br>On May 14, 2024, at 8:06 a.m., the surveyor observed ULP-E provide assistance to another resident (R8) in the facility dining room. Without performing hand hygiene, and after administering medications to the other resident, ULP-E entered R1's room and applied a pair of gloves. Upon entry to R1's room, the surveyor observed ULP-C already in R1's room wearing gloves. ULP-E assisted ULP-C with a stand lift transfer for R1 from wheelchair to the toilet, ULP-C lowered R1's pants, ULP-E lowered the stand lift to sit R1 onto the toilet, both ULP disconnected R1 from the stand lift, and removed the stand lift sling. ULP-C removed a urine soiled incontinent liner from R1's incontinent pull up and applied a clean incontinent liner. Without removing gloves or performing hand hygiene, ULP-C and ULP-E exited the bathroom to provide privacy for R1. ULP-C touched the standing lift and ULP-E touched R1's counter with soiled gloves. ULP-C and ULP-E reentered the bathroom, placed sling onto R1, applied sling to the stand lift, cued R1 to stand, ULP-E operated the lift to a stand position, and ULP-C then assisted with perineal (private area) cares. Without changing gloves or performing hand hygiene, ULP-C pulled up the incontinent pull up and pants. ULP-C and ULP-E then guided the stand lift to the wheelchair, lowered the stand lift to sit R1 into the wheelchair, and removed the sling. ULP-E assisted R1 to wash their hands at sink, ULP-C removed gloves and performed hand hygiene, then ULP-E removed their gloves and performed hand hygiene.<br><br>On May 14, 2024, at 9:55 a.m., the surveyor observed ULP-C and ULP-E getting R5 out of bed and ready for their day. ULP-C and ULP-E performed hand hygiene and applied gloves. | 0 510 | | |

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| 0 510 | Continued From page 3<br>They transferred R5 to their standard wheelchair (w/c) and brought R5 to the bathroom. During the transfer to the toilet, R5 held onto a grab bar next to the toilet and stood while ULP-C and ULP-E each removed a soiled brief (R5 had two briefs on with one over the other). Both ULPs cleaned R5's peri area with wet wipes then sat R5 on the toilet. With soiled gloves, ULP-E left the bathroom and made R5's, bed touching R5's sheets and pillows. With soiled gloves, ULP-C put a clean brief around R5's ankles while R5 sat on the toilet, then left the bathroom, opened the closet door and handled R5's clothing to pick out an outfit. The surveyor observed both bathroom garbage containers which did not have discarded gloves in them. With soiled gloves, ULP-E handled R5's shoes and socks. With soiled gloves, both ULPs assisted R5 with dressing, putting on a shirt and then pants around R5's ankles. With soiled gloves, ULP-C wet a washcloth and wiped areas around and inside R5's eye socket to clean and clear mucus from R5's eyes and wiped R5's face and hair. With soiled gloves, ULP-C used a dry towel to dry R5's face. With soiled gloves, ULP-E handled R5's slippers. ULP-E then removed their soiled gloves and washed their hands with soap and water for the first time since beginning R5's cares. ULP-E applied a new pair of gloves. With soiled gloves, ULP-C brushed R5's teeth and provided a cup of water for R5 to swish and spit water. ULP-C then removed their gloves for the first time since cares began but did not perform hand hygiene. The surveyor observed ULP-C's glove removal, but they still had a pair of gloves on without applying a new pair (ULP-C was wearing more than one pair of gloves at a time). ULP-C and ULP-E then assisted R5 to a stand to pull up his clean brief and pants. R5 had a bowel movement (BM) and ULP-C performed peri cares using wet wipes; ULP-C did not remove their | 0 510 | | |

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| 0 510 | Continued From page 4<br><br>soiled gloves or perform hand hygiene after completing peri cares. With soiled gloves, ULP-C pulled up R5's clean brief and pants. With soiled gloves, ULP-C assisted R5 with ULP-E and transferred R5 into their Broda Chair (a specialized type of w/c). ULP-C then removed their gloves and washed their hands with soap and water for the first time since cares began. ULP-E removed their gloves and washed their hands with soap and water.<br><br>On May 14, 2024, at 9:22 a.m., ULP-E stated they received training on hand hygiene and perineal cares in a classroom setting. ULP-E stated hand hygiene should be performed before and after meals, before and after toileting, in between each resident, with medication pass, and before entering or exiting a resident's room. ULP-E stated they just forgot to perform hand hygiene between the two residents.<br><br>On May 14, 2024, at 9:45 a.m., director of nursing (DON)-A stated ULP attend a training at their corporate office related to infection control. DON-A stated they will periodically conduct audits on hand hygiene and will complete "one off trainings" if they notice a break in infection control. DON-A stated they completed 30-day supervisory visits related to infection control.<br><br>On May 14, 2024, at 10:05 a.m., the surveyor interviewed both ULP-C and ULP-E. ULP-C stated they did perform hand hygiene after touching R5's soiled brief and performing peri cares. The surveyor explained both garbage's were observed and soiled gloves were not in the garbage cans at the time. ULP-C again asserted they changed gloves and performed hand hygiene. ULP-C then stated they did not perform hand hygiene because they were double gloved | 0 510 | | |

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| 0 510 | Continued From page 5<br><br>(the act of wearing one pair of gloves over another, then removing the first layer when moving from a dirty task to a clean task) and removed the soiled gloves instead of performing hand hygiene. ULP-C stated, "[the licensee] absolutely did not train us to double glove, but I do it all the time." ULP-E stated they did not remove their soiled gloves and perform hand hygiene like they were trained and should have done so after handling R5's soiled brief and performing peri cares. ULP-E stated they never double glove, and the licensee did not train them to do it. ULP-C stated the surveyor did not see what they thought they saw. ULP-C then stated they did not remove their soiled gloves and perform hand hygiene when they should have. ULP-C stated they understood why double gloving was not a replacement for hand hygiene.<br><br>On May 14, 2024, at 11:15 a.m., director of nursing (DON)-A and regional clinical operations manager (RCOM)-G stated staff should never double glove as there was a risk of contaminating the second layer of gloves. They stated they did not teach double gloving to their staff. They stated one pair of gloves should be worn at a times, staff should remove gloves and perform hand hygiene when moving from a dirty to clean task. DON-A stated they do perform hand washing audits and conduct additional education if needed.<br><br>The Center for Disease Control (CDC) Hand Hygiene Guidance last reviewed on January 30, 2020, indicated The Core Infection Prevention and Control Practices for Safe Care Delivery in All Healthcare Settings recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) include the following strong recommendations for hand hygiene in healthcare settings: | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>"Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications:<br>- Immediately before touching a patient<br>- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices<br>- Before moving from work on a soiled body site to a clean body site on the same patient<br>- After touching a patient or the patient's immediate environment<br>- After contact with blood, body fluids, or contaminated surfaces<br>- Immediately after glove removal<br>Healthcare facilities should:<br>- Require healthcare personnel to perform hand hygiene in accordance with Centers for Disease Control and Prevention (CDC) recommendations<br>- Ensure that healthcare personnel perform hand hygiene with soap and water when hands are visibly soiled<br>- Ensure that supplies necessary for adherence to hand hygiene are readily accessible in all areas where patient care is being delivered<br>Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands."<br><br>The licensee's Hand Hygiene policy dated July 23, 2021, indicated:<br>"1. When Hands Should be Washed. Hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: | 0 510 | | |

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| 0 510 | Continued From page 7<br>a. Before and after direct contact with a client<br>b. If moving from a contaminated-body site to a clean-body site during client care<br>c. After contact with environmental surfaces or equipment in the immediate vicinity of the client<br>d. After removing gloves or gowns<br>e. Before eating and after using a restroom"<br><br>The licensee's Procedure for Using Gloves policy dated July 23, 2021, indicated, " POLICY: Gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container." Further it indicated: "PROCEDURE:<br>1. Wash Hands<br>2. Apply gloves to both hands<br>3. Complete task. If gloves become torn or heavily soiled and additional tasks must be performed for the client, then change the gloves (washing hands before putting on new gloves before starting the next task.<br>4. Place any contaminated materials in proper receptacle - such as biohazardous waste for wound care dressings.<br>5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull off, turning inside out with first glove inside the second glove.<br>6. Dispose of used gloves in proper receptacle - biohazardous if they have contaminated material on them.<br>7. Rewash hands."<br><br>No further information provided. | 0 510 | | |

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| 0 510 | Continued From page 8<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>The licensee failed to maintain the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents and staff.<br><br>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).<br><br>The findings include:<br><br>On May 14, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D and director of maintenance (DOM)-H. During the facility tour, survey staff observed the following items: | 0 800 | | |

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| | 39425 | A. BUILDING: _____ B. WING _____ | 05/15/2024 |

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| HAYDEN GROVE OF ST ANTHONY | 2601 STINSON PARKWAY ST ANTHONY, MN 55418 |

| (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 |
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| 0 800 | Continued From page 9<br><br>On the third floor by resident units 322 and 310, it was observed that both rated smoke compartment doors did not close when released from the hold-open magnet. The doors are required to close and positively latch when released from the hold-open magnet to maintain fire integrity.<br><br>In the elevator lobby on the third floor, it was observed that the rated elevator door did not close when released from the hold-open magnet. The door is required to close and positively latch when released from the hold-open magnet to maintain fire integrity.<br><br>In the trash room by resident unit 228 on the second floor, it was observed that the rated door did not latch when tested.<br><br>In the exercise room on the second floor, it was observed that the door from the corridor was propped open with a kick-down door stop. The kick-down doorstop will prevent the door from closing in the event of a fire.<br><br>In the food manager's office on the first floor, it was observed that the sprinkler head was missing and that the sprinkler pipe was capped off.<br><br>In the theater on the parking garage level, it was observed that the door from the corridor was propped open with a kick-down door stop. The kick-down doorstop will prevent the door from closing in the event of a fire.<br><br>On May 14, 2024, at 11:00 a.m., LALD-D and DOM-H visually verified these deficient findings at the time of discovery. | 0 800 | | |

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| 0 800 | Continued From page 10<br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. | 0 810 | | |

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| 0 810 | Continued From page 11<br><br>This MN Requirement is not met as evidenced by:<br>Based on the interview and record review, the licensee failed to develop the fire safety and evacuation plan with the required content, failed to provide the required training, and failed to provide the required drills. This had the potential to directly affect all residents, staff, and visitors.<br><br>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).<br><br>The findings include:<br><br>On May 14, 2024, at 1:30 p.m., licensed assisted living director (LALD)-D, director of maintenance (DOM)-H, and regional director of operation (RDO)-F provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.<br><br>EMERGENCY EVACUATION PLAN<br>During the facility tour on May 14, 2024, at 11:30 a.m. with LALD-D and DOM-H, it was observed that the posted fire safety and evacuation plan on the garage level was not accurate depictions of the egress route and were not matched to the installed overhead exit signage location.<br><br>On the door next to the west elevator lobby to the parking garage, it was observed that an overhead | 0 810 | | |

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| 0 810 | Continued From page 12<br><br>exit sign was installed on the elevator lobby side of the door, but the door was not identified as an exit on the posted evacuation plan.<br><br>On the door next to the east elevator lobby to the parking garage, it was observed that an overhead exit sign was installed on both the elevator lobby side of the door and the parking garage side of the door. However, the posted evacuation plan did not identify the door as an exit from the lobby to the parking garage.<br><br>During the facility tour on May 14, 2024, at 11:00 a.m., LALD-D verified that the posted fire safety and evacuation plans did not accurately depict the egress route and that the egress route from the parking garage level needs to be revised.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>The FSEP did not include the facility-specific procedures for resident movement, evacuation or relocation during a fire or similar emergency. The facility Emergency Preparedness plan did include some provisions for the evacuation of residents but did not specify how to move or evacuate residents during a fire, including the identification of unique or unusual resident needs for evacuation.<br><br>During the interview on May 14, 2024, at 2:00 p.m., LALD-D stated the focus of the FSEP was fire safety, and they had not been focused on the resident movement or evacuation in case of a fire or similar emergency. LALD-D confirmed that the FSEP was to be updated with the facility-specific fire safety and the facility's building layout and environmental risks.<br><br>TRAINING<br>Record review of the available documentation | 0 810 | | |

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| 0 810 | Continued From page 13<br><br>indicated employees did not receive training twice per year after initial hire.<br><br>During the interview on May 14, 2024, at 2:00 p.m., LALD-D stated the licensee provided annual training on the fire safety and evacuation plan to employees, but not twice per year after the initial hire, as required by statute. LALD-D confirmed there was no further documented training for the staff on the fire safety and evacuation plan as required by statute.<br><br>DRILLS<br>Provided documentation indicated that the drills were conducted on 12/4/23 at 11:05 a.m., 12/9/23 at 9:54 a.m., 1/11/24 at 3:20 p.m., and 3/20/24 at 1:30 p.m., with no further drills being documented. The provided documentation indicated the drills that were conducted did not incorporate evacuation procedures.<br><br>During the interview on May 14, 2024, at 2:00 p.m., LALD-D verified that the licensee failed to provide evacuation drills twice per year per shift and every other month as required and confirmed that there were no further documented drills.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current | 01730 | | |

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| 01730 | Continued From page 14<br><br>individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and maintain a current individualized medication | 01730 | | |

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| 01730 | Continued From page 15<br><br>management record for each resident to include all required content for one of three residents (R1).<br><br>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).<br><br>The findings include:<br><br>R1 admitted to the licensee on July 24, 2023, and began receiving assisted living services.<br><br>R1's Attachment E: Service Plan Agreement signed May 13, 2024, indicated R1 received assistance with activities, bathing, reorientation, behavior management, escorts, dressing, grooming, nail care, oral care, vital sign monitoring, housekeeping, laundry, repositioning, transfers with use of stand lift, toileting, and medication management. In addition, the service plan included the following content of the medication management plan:<br>- Documentation of specific resident instructions relating to the administration of medications for staff was on the service plan / medication administration record (MAR);<br>- Licensed nursing staff were responsible for monitoring medication supplies and ensuring that medication refills were ordered on a timely basis;<br>- Medication administration may be delegated to an unlicensed personnel (ULP) and were listed on the service plan; and<br>- Staff notified a registered nurse or appropriate | 01730 | | |

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| 01730 | Continued From page 16<br><br>licensed health professional in person or by the telephone when a problem arose with medication management services as listed on the instructions to the ULP.<br><br>On May 14, 2024, at 9:01 a.m., the surveyor observed ULP-E administer oral medications to R1.<br><br>R1's Medication Sheet dated May 1, 2024, through May 31, 2024, included lidocaine pain patch 4 percent (%) apply three patches to clean intact skin once daily as needed (PRN) on for 12 hours and off for 12 hours. The document lacked specific resident instructions on where the lidocaine pain patch should be applied.<br><br>R1's Master Assessment dated May 10, 2024, indicated R1 medications were administered by ULP, and medications were kept in a locked medication cart.<br><br>R1's medication management plan comprised of multiple documents lacked specific written instructions for resident medication administration.<br><br>On May 14, 2024, at 1:11 p.m., director of nursing (DON)-A stated the pharmacy enters the prescriber orders into the computer system MAR and the registered nurse (RN) would add additional administration instructions to the order if needed. DON-A stated they believed R1's lidocaine patches were rarely applied and were to be applied to the right shoulder and hip however, they would attempt to gain clarification on it. DON-A stated the location of the patches should have been added to the order however, it was missed. | 01730 | | |

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| 01730 | Continued From page 17<br><br>On May 14, 2024, at approximately 1:35 p.m., DON-A stated R1's lidocaine patch should be applied to the lower back, and they had located the information in the prescriber's order.<br><br>The licensee's Individualized Medication, Treatment & Therapy Management Plans dated May 24, 2022, read, "RN develop a medication management plan for each resident receiving medication management services. The medication management plan will include:<br>a. Statement of the medication management services provided to the resident<br>b. Description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions<br>c. Documentation of specific resident instructions relating to the administration of medications<br>d. Identification of persons responsible for monitoring and ensuring timely refills of medications<br>e. Identification of medication management tasks that may be delegated to an unlicensed person<br>f. Procedure for notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services<br>g. Resident-Specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medications used to prevent possible complications or adverse reactions."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |

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| 01890 | Continued From page 18 | 01890 | | |
| 01890 SS=D | 144G.71 Subd. 20 Prescription drugs<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review the licensee failed to discard expired medication for two of 11 residents (R6, R7) in the secured unit.<br><br>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).<br><br>The findings include:<br><br>On May 13, 2024, at approximately 9:45 a.m., the surveyor observed the secured unit medication cart and observed the following expired medications:<br>- R6 loperamide 2 milligram (mg) capsule take one capsule by mouth three times daily as needed (PRN) and cetirizine 10 mg take one tablet by mouth daily PRN with an expiration date of March 28, 2024; and<br>- R7 acetaminophen 500 mg take one tablet | 01890 | | |

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| 01890 | Continued From page 19<br><br>every four hours PRN with an expiration date of April 3, 2024.<br><br>On May 13, 2024, at 10:09 a.m., unlicensed personnel (ULP)-I stated there was a list of time sensitive expiration dates on the wall and when they had an expired medication, they would let the director of nursing (DON) know. ULP-I stated the DON would then dispose the expired medication.<br><br>On May 14, 2024, at 9:45 a.m., DON-A stated they checked the medication carts for expired time sensitive medication weekly however, they did not complete a full medication cart audit to include as needed (PRN) medications.<br><br>The Disposition or Disposal of Medication policy dated January 23, 2023, read, "if the medications have been stored outside the client's private living space, they must be disposed of in the med safe consistent with Minnesota PCA requirements, except for controlled substances".<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01910 SS=F | 144G.71 Subd. 22 Disposition of medications<br><br>(a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. | 01910 | | |

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| 01910 | Continued From page 20<br><br>(b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.<br>(c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, and names of staff and other individuals involved in the disposition for one of one discharged resident (R2).<br><br>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).<br><br>The findings include:<br><br>R2 was discharged from the licensee on May 24, 2024. | 01910 | | |

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|---|---|
| HAYDEN GROVE OF ST ANTHONY | 2601 STINSON PARKWAY ST ANTHONY, MN 55418 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 21<br><br>R2's diagnoses included Alzheimer's disease, heart disease, hypertension, dysphagia, stenosis of cerebral (brain) artery, hemiplegia (paralysis of one side of the body) and hemiparesis (one sided muscle weakness), tremor, and restless leg syndrome.<br><br>R2's Attachment E: Service Plan Agreement signed February 27, 2024, indicated R2 received assistance with bathing, escorts, dressing, nail care, compression stockings, vital sign monitoring, housekeeping, laundry, and medication administration.<br><br>R2's Medication Sheet dated March 25, 2024, through April 24, 2024, indicated the following medications were administered to R3 by the licensee: carbidopa-levodopa 25 milligrams (mg)-100 mg, memantine hydrogen chloride (HCL) 5 mg, acetaminophen 1000 mg, triamcinolone 0.1 percent (%) topical cream, tamsulosin 0.4 mg, simvastatin 40 mg, and PreserVision AREDS soft gels.<br><br>R2's Discharge Summary dated April 24, 2024, indicated all medications were provided to resident or their representative with signed acknowledgement.<br><br>R2's nursing progress note dated April 24, 2024, indicated resident discharged from the licensee to a different facility and skilled nursing was to follow up with wound care at the new community.<br><br>R2's record lacked a medication disposition that included medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, and names of staff and other individuals involved in the | 01910 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 05/15/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HAYDEN GROVE OF ST ANTHONY | 2601 STINSON PARKWAY ST ANTHONY, MN 55418 |

| (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 |
|---|---|---|---|---|
| 01910 | Continued From page 22<br>disposition.<br><br>On May 13, 2024, at 11:53 a.m., director of nursing (DON)-A stated they typically document in the discharge summary if medications were given to residents and/or resident family members. DON-A stated R2 was provided their Parkinson's medication because it was just delivered from pharmacy. DON-A stated they did not have any documentation of the medication or quantity of medications provided to R2. DON-A stated they have never completed documentation that included medication name or quantity of medications sent with a resident or resident family member upon discharge.<br><br>The licensee's Disposition or Disposal of Medication, dated January 23, 2023, read, "1.Drugs Given to Clients When the Medication Management Services Have Been Terminated<br>a. A resident's current medications that are secured or stored by our agency will be given to the resident or the resident's representative when the resident's medication management services are terminated, except that the conditions listed below must be met before controlled medications belonging to a client will be given to the client or the client's representative.<br>b. Staff will document in the client's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01910 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/13/24*
Time: 11:00:00
Report: 1039241136

# Food and Beverage Establishment Inspection Report



**Location:**
Hayden Grove of St Anthony
2601 Stinson Parkway
St Anthony, MN55418
Hennepin County, 27

**Establishment Info:**
ID #: 0042672
Risk:
Announced Inspection: No

**License Categories:**

Expires on: 12/31/24

**Operator:**

Phone #: 6126887190
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.

No NEW orders were issued during this inspection.

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

Food service for establishment is provided by the 3rd party vendor Unidine. MDH did not conduct an inspection of the food service.

**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 1039241136 of 05/13/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

**Inspection report reviewed with person in charge and emailed.**

Signed:_____
Establishment Representative

Signed:_____
Aron Goodner
Public Health Sanitarian I
Freeman Building
aron.goodner@state.mn.us