DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

September 12, 2022

Administrator
Hayden Grove Senior Housing
8715 Portland Avenue South
Bloomington, MN 55420

RE: Project Number(s) SL36913015

Dear Administrator:

On August 18, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the May 11, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jess Gallmeier, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

Electronically Delivered

June 9, 2022

Administrator
Hayden Grove Senior Housing
8715 Portland Avenue South
Bloomington, MN 55420

RE: Project Number SL36913015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on May 11, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 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.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health 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 (a)(5)(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 evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $3500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction 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 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 licensing 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. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

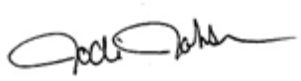
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jodi Johnson, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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 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: SL36913015 On, May 9, 2022, through May 11, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 111 residents, 61 of whom were receiving services under the provider's Assisted Living with Dementia Care license. On May 10, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of I, widespread, level three.	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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) 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 following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated May 9, 2022, for the specific Minnesota Food Code deficiencies.	0 480		

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0 480	Continued From page 2 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
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 effective infection control program to comply with accepted health care, medical, and nursing standards for infection control and current recommendations for COVID-19 when three of six employees (unlicensed personnel (ULP)-E, lead supervisor (LS)-I, and ULP-E) failed to wear appropriate PPE when in contact with residents. This had the potential to affect all residents, staff, and visitors. The licensee also failed to ensure all contracted staff wore a mask around residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 510		

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0 510	Continued From page 3 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). ULP-E On May 9, 2022, at 1:21 p.m. ULP-E was observed to assist resident into bed with goggles sitting on top of ULP-E's head. LS-I On May 9, 2022, at 11:21 a.m. and 12:05 p.m. LS-I was observed serving residents in the dining room while wearing a mask below LS-I's chin. On May 10, 2022, at 11:30 a.m. LS-I was observed serving lunch to residents in the dining room while wearing a mask below LS-I's chin. ULP-C On May 10, 2022, during a continuous observation from 7:57 a.m. to 8:17 a.m., ULP-C was wearing eye protection on the top of ULP-C's head, not covering eyes, while assisting R3 with transferring and activities of daily living (ADLs). On May 10, 2022, at 8:17 a.m. ULP-C stated she had infection control training. ULP-C acknowledged she should wear eye protection when doing cares, but forgot to put it on. On May 9, 2022, at 2:00 p.m. licensed assisted living director (LALD)-A stated that the current PPE policy is masks are worn in common areas and eye protection for direct patient care. On May 11, 2022, at 12:20 p.m. LALD-A confirmed the licensee's policy on wearing masks in common areas. LALD-A further stated the	0 510		

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0 510	Continued From page 4 kitchen staff were contracted employees and were responsible to follow the same policies. The Minnesota Department of Health (MDH) guidance titled, "COVID-19 PPE and Source Control Grids - for congregate care settings, by community transmission level", dated April 7, 2022, indicated during "substantial" or "high" levels of community transmission (based on the Centers for Disease Control and Prevention (CDC) online data tracking system), caregivers must wear a face mask (source control) and eye protection while working with clients without suspected or confirmed SARS-CoV-2 infection. The CDC COVID Data Tracker on May 9, 2022, and May 10, 2022, indicated Hennepin County, MN (the county of the licensee) was at a "substantial" level of community transmission, which indicated the use of a face mask and eye protection while working with clients. The licensee's PPE policy CV-001 dated January 2014, indicates use of masks in common areas and use of goggles with direct patient care. No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
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: (1) posting the 911 emergency number in	0 640		

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0 640	Continued From page 5 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 support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of residents). During a facility tour on May 9, 2022, at approximately 9:55 a.m. an observation of the common areas lacked information and phone numbers for reporting to MAARC, and the 911 emergency number was not posted in common areas and near telephones provided by the assisted living facility. On May 9, 2022, at 12:10 p.m. licensed assisted living director (LALD)-A confirmed the 911 sign and VA reporting number should be by the phone at the front desk since the residents and family usually use it. LALD-A further confirmed they	0 640		

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0 640	Continued From page 6 would add it. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to maintain a tuberculosis (TB) infection control program based on guidelines by the Center for Disease Control (CDC) and Minnesota Department of Health by ensuring TB health screenings were completed for one of three employees (unlicensed personnel (ULP)-E), and TB education was provided for one of three employees (director of nursing (DON)-B) with employee health records reviewed.	0 660		

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0 660	Continued From page 7 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). ULP-E was hired October 12, 2021, to provide direct care services to the licensee's assisted living with dementia care facility. ULP-E had a chest x-ray completed October 26, 2021, but the employee's record lacked evidence a TB history and symptom screen was completed. On May 10, 2022, at 3:00 p.m. licensed assisted living director (LALD)-A confirmed they did not have a TB screen for ULP-E, and that it was a requirement. The licensee's TB prevention and control policy dated January 2014, indicated prior to contact with residents, all employees would have a TB screen. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810		

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0 810	Continued From page 8 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors.	0 810		

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0 810	Continued From page 9 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 residents). The findings include: During interview on May 10, 2022, at 1:00 a.m., the director of maintenance (DOM)-H stated they were not currently doing the evacuation drills. Review of the fire safety policy showed no record of employee evacuation drills. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain	0 950		

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0 950	Continued From page 10 information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the opportunity to identify a designated representative for five of five residents (R2, R3, R5, R6, R7) with contracts reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee converted their comprehensive home care license to an assisted living with dementia care license on August 1, 2021.	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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
0 950	Continued From page 11 R2 R2 began receiving assisted living services on January 11, 2022. R2's contract signed January 12, 2022, lacked documentation R2 was given the opportunity to identify or to decline a designated representative. R3 R3 began receiving assisted living services on December 6, 2021. R3's contract signed December 6, 2021, lacked documentation R3 was given the opportunity to identify or to decline a designated representative. R5 R5 began receiving assisted living services on January 11, 2022. R5's contract signed January 11, 2022, lacked documentation R5 was given the opportunity to identify or to decline a designated representative. R6 R6 began receiving comprehensive services on May 13, 2021. R6's assisted living contract signed October 24, 2021, lacked documentation R6 was given the opportunity to identify or to decline a designated representative. R7 R7 began receiving assisted living services on September 28, 2021. R7's contract signed September 28, 2021, lacked documentation R7 was given the opportunity to identify or to decline a designated representative. On May 10, 2022, at 2:50 p.m. licensed assisted living director (LALD)-A verified there was a section in the assisted living contract where residents could designate a representative, but there was not a separate document, with the	0 950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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0 950	Continued From page 12 required verbiage. LALD-A stated all residents received the same assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
0 970 SS=C	144.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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0 970	Continued From page 13 The licensee's assisted living contract included a clause that indicated the resident would waive the licensee's liability for health, safety, or personal property of a resident. Section 31.0 indicated the resident will hold management harmless. On May 11, 2022, at 9:00 a.m. licensed assisted living director (LALD)-A verified all of the information noted above, and further indicated all resident contracts had the same content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01610 SS=D	144G.70 Subd. 2 (a-b) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any 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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01610	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted an initial assessment for two of six residents (R5 and R7) as required with records reviewed. 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: R5 R5 admitted to services on January 11, 2022. R5 had a service plan dated April 25, 2022, indicating services included medication administration and assistance with activities of daily living (ADLs). R5's record lacked evidence an initial assessment was completed on or before admission to the facility. R7 R7 admitted to services on September 28, 2021. R7 had a service plan dated February 21, 2022, indicating services included medication administration and assistance with ADLs.	01610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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01610	Continued From page 15 R7's record lacked evidence an initial assessment was completed on or before admission to the facility. On May 10, 2022, at 3:50 p.m. licensed assisted living director (LALD)-A and RN-D confirmed assessments should be completed initially upon admission, at 14 days and every 90 days, but they were between staff and missed some residents' assessments. The licensee's initial and on-going nursing assessment policy dated January 2014, indicated an initial assessment will be completed by the RN prior to admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01610		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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01620	Continued From page 16	01620		

be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.
(e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

This MN Requirement is not met as evidenced by:
Based on interview and record review the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment using the uniform assessment tool on day 14 for five of six residents (R2, R4, R5, R6, R7) and on or before day 90 for one of six residents (R7) as required with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).

The findings include:

R2
R2 began receiving assisted living services on January 11, 2022.

R2's record included an initial assessment dated January 11, 2022, and a reassessment dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 17 February 9, 2022, which was 29 days after the start of services (15 days late). R4 R4 began receiving assisted living services on January 20, 2022. R4's service plan dated January 20, 2022, indicated R4 received services to include assistance with medication administration and activities of daily living (ADLs). R4's record included an initial assessment dated January 18, 2022, and a reassessment dated February 11, 2022, which was 22 days after the start of services (7 days late). R5 R5 admitted to services on January 11, 2022. R5 had a service plan dated April 25, 2022, indicating services to include medication administration and assistance with ADLs. R5's record included a uniform assessment tool indicating it was a 14-day assessment dated February 8, 2022, which was 28 days after the start of services (14 days late). R6 R6 admitted to services on May 13, 2021. R6 had a service plan dated February 25, 2022, indicating services to include medication administration and assistance with ADLs. R6's record included a uniform assessment tool	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 18 indicating it was a 14-day assessment dated June 9, 2021, which was 26 days after the start of services (12 days late). R7 R7 admitted to services on September 28, 2021. R7 had a service plan dated February 21, 2022, indicating services to include medication administration and assistance with ADLs. R7's record included a uniform assessment tool indicating it was a 14-day assessment dated November 4, 2021, which was 37 days after the start of services (23 days late). R7's record included a uniform assessment tool indicating it was a 90-day assessment dated February 16, 2022, which was 104 days after the start of services (14 days late). On May 10, 2022, at 3:50 p.m. licensed assisted living director (LALD)-A and RN-D confirmed assessments should be completed initially upon admission, at 14 days, and every 90 days, but they were between staff and missed some residents' assessments. The licensee's initial and on-going nursing assessment policy dated January 2014, indicated a 14-day assessment is completed up to 14-days after start of services and ongoing assessments to be completed no more than every 90 days. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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 19	01640		
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. (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 finalize a current written service plan within 14 calendar days for one of six residents (R2) with records reviewed. 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	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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 20 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 began receiving assisted living services on January 11, 2022. On May 10, 2022, at 8:30 a.m. unlicensed personnel (ULP)-K was observed to administer medications to R2. R2's caregiver service documentation from April 1, 2022, through May 10, 2022, indicated R2 received daily assistance with toileting and "personal cares." R2's record included an assisted living contract signed January 12, 2022, but lacked an individualized service plan. On May 11, 2022, at 12:22 p.m. licensed assisted living director (LALD)-A acknowledged R2's record lacked a signed service plan. LALD-A indicated development of R2's service plan was overlooked. The licensee's Content of Service Plans policy revised July 28, 2021, indicated "All assisted living residents will have an up-to-date service plan identifying services to be provided based on the assessment by the [registered nurse] and/or other licensed health professional." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident service plan included the required content for two of two residents (R3, R4) with records reviewed. This practice resulted in a level two violation (a	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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
01650	Continued From page 22	01650		

violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

R3
R3 began receiving assisted living services on December 6, 2021.

R3's "Service Agreement," identified as the service plan signed December 6, 2021, lacked the following:
- A description of the services to be provided;
- Identification of staff or categories of staff who will provide the service; and
- The methods of monitoring staff providing services.

R4
R4 began receiving assisted living services on January 20, 2022.

R4's "Service Agreement," identified as the service plan signed January 20, 2022, lacked the following:
- A description of the services to be provided;
- Identification of staff or categories of staff who will provide the service; and
- The methods of monitoring staff providing services.

On May 11, 2022, at 8:56 a.m. licensed assisted living director (LALD)-A verified the licensee's document titled "Service Plan" was a care plan created for staff use, and the licensee's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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01650	Continued From page 23 document titled "Service agreement" was the service plan that was signed by the resident or representative indicating agreement to the services to be provided. LALD-A acknowledged the service plan was lacking an individualized description of services to be provided, indication of the categories of staff providing the services, and method of monitoring staff. LALD-A further indicated all residents received the same service plan. The licensee's Contents of Service Plans policy revised July 28, 2021, indicated service plans will include: -A description of the services provided; -Fees for services; -Frequency of each service according to resident assessment and resident preferences; -Schedule and methods of monitoring assessments; -Schedule and methods of monitoring staff providing services; and -A contingency plan that includes: 1. Action taken if the scheduled service cannot be provided 2. Information and method to contact the facility 3. Names and contact information of persons the resident wishes to have notified in an emergency 4. Names and contact information of persons the resident wishes to have notified if there is a significant adverse change in the resident's condition 5. Identification of and information on who has authority to sign for the resident in an emergency 6. Circumstances in which emergency medical services are not to be summoned	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

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01650	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	01650		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure prescriber's orders were transcribed correctly to ensure proper medication administration for one of one resident (R6) with records reviewed. 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	01760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36913	A. BUILDING: _____ B. WING _____	05/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYDEN GROVE SENIOR HOUSING	8715 PORTLAND AVENUE SOUTH BLOOMINGTON, MN 55420

(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
01760	Continued From page 25 situation has occurred only occasionally). R6's diagnoses included Parkinson's disease and generalized anxiety disorder. R6's service plan dated February 25, 2022, indicated R6 received assistance with medication management. R6's After MD Visit Summary dated January 21, 2021, indicated a change to the administration of levodopa medication to be given within 15 minutes of the scheduled times. R6's medication administration sheet (MAR) for April 2022, listed Carbidopa-Levodopa ER tablet (used for Parkinson's disease) by mouth every two hours. R6's MAR failed to include the prescriber's specific directions of medication administration within 15 minutes of the scheduled times. On May 10, 2022, at approximately 11:30 a.m. R6 verbalized frustration with not receiving the Carbidopa-Levodopa medication timely, noting a decline in his independence. On May 11, 2022, at 9:40 a.m. both licensed assisted living director (LALD)-A and director of nursing (DON)-B confirmed R6's medication change had not been transcribed or communicated to the staff. The licensee's requesting and receiving medication prescriptions and refills policy dated January 2014, indicates the nurse will make changes immediately after receiving a change in medication including written directions for the staff.	01760		

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01760	Continued From page 26 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.	01940		

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01940	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of five residents (R3, R4) with records reviewed. 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: R3 R3 began receiving assisted living services on December 6, 2021. On May 10, 2022, at 7:57 a.m. unlicensed personnel (ULP)-C was observed to check the blood glucose level for R3. R3's prescriber order dated November 30, 2021, indicated blood glucose should be tested "four times a day before meals and at bedtime." R3's medication administration record (MAR) for April 1 through May 10, 2022, indicated R3 received blood glucose checks "when up, before meals, and at bedtime." The MAR indicated blood glucose checks were performed five times daily.	01940		

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01940	Continued From page 28 R3's Service Agreement identified as the service plan signed December 6, 2021, did not include blood sugar monitoring as a service provided. R3's Treatment Therapy Plan dated December 3, 2021, indicated R3 received assistance with blood glucose checks "as needed," and was not updated to reflect the current frequency of blood glucose monitoring. On May 11, 2022, at 8:56 a.m. licensed assisted living director (LALD)-A verified the licensee's document titled "Service Plan" was a care plan created for staff use, and the licensee's document titled "Service agreement" was the service plan that was signed by the resident or representative indicating agreement to the services to be provided. LALD-A verified the service plan was lacking an individualized description of services to be provided. R4 R4 began receiving assisted living services on January 20, 2022. On May 10, 2022, at 9:06 a.m. ULP-F was observed to check the blood glucose level for R4. R4's prescriber order dated January 17, 2022, indicated R4's blood glucose levels were to be checked "every day and evening shift." R4's MAR indicated blood glucose levels were monitored daily from April 1 through May 10, 2022. R4's Service Agreement, identified as the service plan signed January 20, 2022, did not include blood sugar monitoring as a service provided.	01940		

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01940	Continued From page 29 R4's record lacked a treatment or therapy management plan with information related to blood glucose monitoring. On May 11, 2022, at 12:11 p.m. registered nurse (RN)-D provided a treatment or therapy management plan for R4 dated May 11, 2022. RN-D verified the document was not developed prior to the survey. RN-D further verified the treatment or therapy management plan should have been in place for R4. The licensee's Medication, Treatment and Therapy Reminders policy revised July, 28, 2021, indicated the RN would conduct a nursing assessment of a client's functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services and develop an individualized medication management plan and/or treatment and therapy individualized plan for the resident based on the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02110 SS=E	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's	02110		

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02110	Continued From page 30 values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure policies and procedures for assisted living with dementia care were provided to residents and the residents' legal and designated representatives at the time of move-in for five of six residents (R2, R3, R4, R5, R7) with records reviewed.	02110		

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02110	Continued From page 31 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 began receiving assisted living services on January 11, 2022, and had diagnoses to include intracranial meningioma (a type of brain tumor). R3 R3 began receiving assisted living services on December 6, 2021, and had diagnoses to include diabetes. R4 R4 began receiving assisted living services on January 20, 2022, and had diagnoses to include diabetes and hypertension (high blood pressure). R5 R5 began receiving assisted living services on January 11, 2022, and had diagnoses to include cerebral vascular accident (stroke) and arthritis. R7 R7 began receiving assisted living services on September 28, 2021, and had diagnoses to include cerebral vascular accident (stroke). R2, R3, R4, R5, and R7's records lacked evidence the resident or their representative were provided the licensee's policies and procedures	02110		

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02110	Continued From page 32 related to assisted living with dementia care as required. On May 11, 2022, at 9:35 a.m. licensed assisted living director (LALD)-A verified the records lacked evidence R2, R3, R4, R5, R7, or their representative received the licensee's dementia care policies and procedures. LALD-A stated newer residents signed a checklist that included receipt of dementia care policies, but it was not included in the document list previously presented to residents upon admission. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110		
02310 SS=I	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R2 and R7) with bedrails. This resulted in an immediate correction order on May 10, 2022, at approximately 10:46 a.m. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death,	02310		

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02310	Continued From page 33 or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's diagnoses includes intracranial meningioma (a type of brain tumor). R2's Service Plan dated February 23, 2022, included daily medication administration and activities of daily living. On May 10, 2022, at 8:47 a.m. the surveyor observed bilateral siderails near the head of R2's bed in the up position. The siderails were attached to the bed frame. R2's siderail assessment dated May 2, 2022, lacked exact measurements. R7 R7's diagnosis includes cerebral vascular accident (stroke). R7's service plan dated May 7, 2022, included daily medication administration and activities of daily living. On May 9, 2022, at approximately 3:30 p.m. the surveyor observed bilateral bedrails near the head of the bed in the up position, and secured to the bed frame. R7's record lacked evidence of a side rail assessment by the licensee; however, a side rail	02310		

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02310	Continued From page 34 assessment was provided on May 10, 2022, after it was requested by the surveyor. On May 10, 2022, at 9:30 a.m. registered nurse (RN)-D and director of nursing (DON)-B confirmed R7 did not have a side rail assessment completed prior to the surveyor's request. In addition, the completed side rail assessment lacked exact measurements. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." At 10:46 a.m., RN-D confirmed that there were a total of five residents with siderails. RN-D and LALD-A were unaware that exact measurements were needed when completing the side rail assessment. The licensee's Siderails policy last dated June 4, 2021, indicated when the licensee was aware a resident was utilizing siderails (a medical device)	02310		

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02310	Continued From page 35 on a bed, the licensee would assess the use, educate the resident, and when appropriate, the responsible person, regarding the risks and benefits of siderails, and verify that the siderail in use was of a safe design and utilized consistent with the manufacturer's directions. Staff from the licensee would determine if the siderail was considered to be safe. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On May 10, 2022, the immediacy of correction order 2310 was removed; however, non-compliance remains at a scope and level of widespread, level three (I). TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Minnesota Department Of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *05/09/22*
Time: 11:00:57
Report: 8075221102

Food and Beverage Establishment Inspection Report

Location:
Hayden Grove Senior Housing
8715 Portland Avenue South
Bloomington, MN55420
Hennepin County, 27

Establishment Info:
ID #: 0039165
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9529353400
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

No irreversible registering temperature measuring device onsite for use with hot water sanitizing dish machine.

Comply By: 06/09/22

2-100 Supervision

2-102.12AMN

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

No state certified food protection manager.

Comply By: 07/09/22

4-600 Cleaning Equipment and Utensils

4-603.14

MN Rule 4626.0875 Wash food-contact surfaces of equipment and utensils to effectively remove or loosen soils.

Deli slicer is reportedly wiped with sanitizer without first being washed with a detergent. Follow the order: 1) wash, 2) rinse, 3) sanitize.

Comply By: 05/09/22

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

Quaternary Ammonium: = 200ppm at Degrees Fahrenheit
Location: wiping cloth sanitizer bucket
Violation Issued: No

Wash Temp: = at 158 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Rinse Temp: = at 185 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Utensil Surface Temp: = at 168 Degrees Fahrenheit
Location: dish machine
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: cooler - tuna salad
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: cooler - turkey
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: walk in cooler - deli meat
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: walk in cooler - cut melon
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: cooler - yogurt
Violation Issued: No

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

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 8075221102 of 05/09/22.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/ /_____

Signed:_____ Signed:_____

Eric Mena
Food Service Director

Erin Tibbetts
Public Health Sanitarian
Metro District Office
651-201-3987
erin.tibbetts@state.mn.us