Electronically delivered

February 24, 2022

Administrator
Hawthorne House, Inc.
1100 Idaho Avenue
Golden Valley, MN 55427

RE: Project Number(s) SL23395015

Dear Administrator:

On February 3, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine correction of orders found on the evaluation completed on November 19, 2021. The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the November 19, 2021 evaluation.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state licensing orders issued pursuant to the last evaluation completed on November 19, 2021, found not corrected at the time of the February 3, 2022, follow-up evaluation and/or subject to penalty assessment are as follows:

0110-Assisted Living Director License Required-144g.10 Subdivision 1a = $500.00
0630-Compliance With Requirements For Reporting Ma-144g.42 Subd. 6 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on February 3, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in

§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.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970
Health.HRD.Appeals@state.mn.us

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.

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, 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.

Sincerely,

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23395	A. BUILDING: _____ B. WING _____	R 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HOUSE INC	1100 IDAHO AVENUE GOLDEN VALLEY, MN 55427

(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 In accordance with Minnesota Statutes, section 144G.08 to 144G.95 this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: Project # SL 23395015 On February 3, 2022, Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on November 19, 2021. At the time of the survey, there were two active residents receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State 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.	
{0 110} SS=F	144G.10 Subdivision 1a Assisted living director license required	{0 110}		

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{0 110}	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-B was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's 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 the residents). The findings include: LALD-B started employment with licensee on January 1, 2016, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On February 3, 2022, at approximately 10:00 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) indicated LALD-B held a current assisted living director license but was not listed as Director of Record for the licensee. On February 3, 2022, at approximately 11:30	{0 110}		

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{0 110}	Continued From page 2 a.m., LALD-B acknowledged they were not listed as Director of Record with BELTSS and stated they were not aware they needed to be registered as Director of Record for licensee. The licensee lacked a policy to require LALD to register with BELTSS as the Director of Record for the facility. No further information provided.	{0 110}		
{0 630} SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of two residents (R1 and 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	{0 630}		

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{0 630}	Continued From page 3 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's diagnoses included a brain injury. R1's Vulnerable Adult Assessment, dated May 17, 2021, indicated the following vulnerabilities: language barrier, unable to ambulate safely without device, unable to use phone, disability, can abuse others, can be abused, and unable to report abuse. R1's Home Health Aide Plan, dated January 6, 2022, indicated R1 had poor memory, difficulty to follow instructions, mood swings, limited attention span and poor judgment but lacked interventions to minimize the risk of abuse to self or others. R1's medical record lack an IAPP with statements of specific measures to be taken by staff to minimize the risk of abuse to R1. R2's diagnoses included post subarachnoid hemorrhage (a type of stroke caused by bleeding into the space surrounding the brain). R2's Assisted Living Home Health Aide Care Plan, dated January 1, 2022, indicated R2 has pain. R2's medical record lacked an IAPP with statements of specific measures to be taken by staff to minimize the risk of abuse to R2.	{0 630}		

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{0 630}	Continued From page 4 On February 3, 2022 at approximately 2:40 p.m., licensed practical nurse (LPN)-C acknowledged the licensee did not have specific statements/measures to be taken by staff to minimize the risk of abuse to residents and other vulnerable adults. The licensee's Abuse Prevention Plan policy, dated August 1, 2021, indicated all admitted residents will be assessed for their susceptibility to abuse by others, their risk to abuse others and statements of the specific measures to be taken by staff to minimize the risk of abuse. No further information was provided.	{0 630}		
{0 810} SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall 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.	{0 810}		

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{0 810}	Continued From page 5 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: No further action required.	{0 810}		

Electronically Delivered

January 13, 2022

Administrator
Hawthorne House Inc
1100 Idaho Avenue
Golden Valley, MN 55427

RE: Project Number(s) SL23395015-0

Dear Administrator:

The Minnesota Department of Health completed an evaluation on November 19, 2021, 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, no immediate fines are assessed.

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 surveys. 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

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place

St. Paul, MN 55164-0970 St. Paul, MN 55164-0970

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,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-281-9796 / 651-215-9697

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0 000	Initial Comments Initial comments *****ATTENTION****** ASSISTED LIVING 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: SL23395015 On November 17, 2021, through November 19, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were two residents receiving services under the provider's Assisted Living 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 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.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by	0 110		

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0 110	Continued From page 1 the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employment of a licensed assisted living director (LALD). This had the potential to affect both of the two residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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 lacked an LALD to manage and supervise assisted living services for the two current residents who received assisted living services. On November 17, 2021 at approximately 9:45 a.m., unlicensed personnel (ULP-B) stated she was the licensed assisted living director. On November 17, 2021, at 11:40 a.m., the Minnesota Board of Executives for Long-Term Services and Support website was reviewed for verification of ULP-B's assisted living director licensure. ULP-B was not listed as having a current LALD license. On November 17, 2021, at 11:50 a.m., ULP-B	0 110		

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0 110	Continued From page 2 confirmed her licensure application for assisted living director was still pending and was not sure why it was not yet approved. On November 17, 2021, at 12:00 p.m., following request for licensee's LALD policy, ULP-B stated the licensee lacked a policy related to licensed assisted living directors. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE November 30, 2021, immediacy removed as confirmed by email communication between ULP-B and MDH evaluation supervisor and BELTSS ALD verification.	0 110		
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract. (c) The commissioner must, in consultation with all interested stakeholders, design the uniform	0 430		

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0 430	Continued From page 3 checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a copy of the uniform disclosure of assisted living services and amenities (UDALSA) for two of two residents (R1 and R2) to include: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted to licensee on June 7, 2018. R1's service plan titled, Hawthorne House Inc. Service Plan, dated June 7, 2018, indicated R1 received services, including medication management, assessment, and personal care services. R1's record did not include a copy of a UDALSA.	0 430		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 430	Continued From page 4 R2 was admitted to the licensee on December 20, 2017. R2's service plan titled, Hawthorne House Inc. Service Plan, dated December 17, 2017, indicated R2 received services, including medication management, care coordination, assessment, and personal care services. R2's record did not include a copy of a UDALSA. On November 19, 2021, at 12:40 p.m., manager/owner (O)-B confirmed R1 and R2 had not received a UDALSA. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are	0 470		

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	23395	A. BUILDING: _____ B. WING _____	11/19/2021

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0 470	Continued From page 5 available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the licensee's staffing plan was posted as required. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on November 17, 2021, at 9:50 a.m., the surveyor observed no posted staff schedule in any area of the facility. On November 17, 2021, at approximately 11:30 a.m., owner (O)-C confirmed the licensee had not	0 470		

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0 470	Continued From page 6 posted staffing schedule as required. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and	0 490		

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0 490	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs for two of two residents (R1 and 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During observations on November 17, 18, and 19, 2021, the surveyor observed no activities to be planned or offered by the licensee for the residents. On November 17, 2021, at approximately 9:20 a.m., during the entrance conference, licensed practical nurse (LPN)-C stated R1 was involved in activities and had a game in his room he would be play with staff when interested. On November 18, 2021, the surveyor observed R1 sitting in his wheelchair in the television room, shouting out to the employees as they walked by. During an interview on November 19, 2021, at approximately 10:30 a.m., R2 stated he was not involved in any activities, but he was fine as some days he would be gone for work. R2 also stated	0 490		

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0 490	Continued From page 8 when the weather was good, he would go for a walk. During an interview on November 19, 2021, at approximately 12:20 p.m., owner (O)-B stated the licensee had not implemented a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by:	0 550		

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0 550	Continued From page 9 Based on observation and interview, the licensee failed to post in a conspicuous place, information about the licensee's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all staff, visitors and residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During facility tour on November 17, 2021, at approximately 9:50 a.m., the surveyor did not observe any grievance procedure or grievance procedure contact information posted in the facility. During an interview on November 18, 2021, at approximately 1:20 p.m., owner (O)-B indicated the grievance procedure content and contact information was not posted in the facility as required. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 550		

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0 550	Continued From page 10 days	0 550		
0 630 SS=F	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include statements of the specific measures to be taken to minimize the risk of abuse for two of two residents (R1 and 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 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:	0 630		

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0 630	Continued From page 11 R1's diagnoses included a brain injury. R1's Vulnerable Adult Assessment dated May 17, 2021, indicated the following vulnerabilities: language barrier, unable to ambulate safely without device, unable to use phone, disability, can abuse others, can be abused, and unable to report abuse. R1's individual abuse prevention plan lacked statements of specific measures to be taken by staff to minimize the risk of abuse to R1. R2's diagnoses included post subarachnoid hemorrhage (a type of stroke caused by bleeding into the space surrounding the brain). R2's Assisted Living Home Health Aide Care Plan dated May 21, 2021, indicated R2 is at risk for bleeding and falls. R2 lacked an individual abuse prevention plan to include statements of specific measures to be taken by staff to minimize the risk of abuse to R2. On November 18, 2021, at approximately 12:40 p.m., licensed practical nurse (LPN)-C stated the licensee did not have specific statements/measures to be taken by staff to minimize the risk of abuse to each resident and other vulnerable adults. The licensee's undated Abuse Prevention Plan policy indicated all admitted residents will be assessed for their susceptibility to abuse by others, their risk to abuse others and statements of the specific measures to be taken by staff to minimize the risk of abuse. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021.	0 630		

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0 630	Continued From page 12 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
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 common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all staff, visitors, and residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 640		

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0 640	Continued From page 13 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee lacked the following: - posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility - posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557 During an observation of the main entry area and common areas on November 17, 2021, at approximately 9:50 a.m., the surveyor did not observe a posting of the 911 emergency number or a posting of information and phone numbers for MAARC to report suspected maltreatment of vulnerable adults. On November 17, 2021, at approximately 11:30 a.m., licensed practical nurse (LPN)-C confirmed the required content had not been posted. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 14 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content and failed to post an emergency preparedness plan prominently. This had the potential to affect all staff, visitors, and residents receiving services under the license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 15 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 17, 2021, at approximately 9:40 a.m., during the entrance conference, the surveyor requested to review the licensee's emergency preparedness plan. During a facility tour on November 17, 2021, at approximately 10:05 a.m., the surveyor did not observe a posting of the licensee's emergency plan, emergency exit diagrams posted in conspicuous places on each floor, or emergency exit diagrams in residents' room. The licensee lacked evidence of the following required content: - a comprehensive program to include infectious diseases and pandemics; - a description of the population served by the licensee; - process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; - procedure for tracking staff and residents; - subsistence needs for staff and residents during emergency situation; - development of policies/procedures to address: - evacuation plan (not customized for the facility); - fire (not customized for the facility); - shelter in place; - a tracking system used to document locations or residents and staff;	0 680		

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0 680	Continued From page 16 - the medical record documentation system to preserve resident information; - emergency staff strategies; and - the facilities role in providing care and treatment at alternative sites; - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy; and -a method of sharing information from the emergency plan with residents and their families; - EP training and testing program; - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. During an interview on November 17, 2021, at approximately 2:10 p.m., owner (O)-B stated staff were not familiar with Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] State Operations Manual which includes the emergency preparedness guidelines). O-B also verified the licensee had not fully developed and implemented an emergency preparedness plan/program. The licensee lacked policies to include the new assisted living licensure requirements, effective	0 680		

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0 680	Continued From page 17 August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall 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	0 810		

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0 810	Continued From page 18 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 required training to residents and employees for fire safety and evacuation. The fire safety and evacuation plan failed to show procedures for resident movement, evacuation, or relocation during a fire or similar emergency. The plan did not include the identification of unique or unusual resident needs for movement or evacuation. This had the potential to affect all current residents, visitors, and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On November 18, 2021, at approximately 10:30 a.m., the licensee provided no documentation verifying the required twice per year staff training or once per year resident training for fire safety and evacuation occurred. The fire safety and evacuation plan did not include specific information on procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for	0 810		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 19 movement or evacuation. On November 18, 2021, at approximately 10:40 a.m., licensed practical nurse (LPN)-C stated the licensee was not currently conducting twice per year trainings for staff or once per year training for able residents. A policy related to a plan for required training of residents and training of employees was requested but not available at the time of survey. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 900 SS=F	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident	0 900		

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0 900	Continued From page 20 promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and execute an assisted living written contract with the required content for two of two residents (R1, 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee converted from a comprehensive home care license to an assisted living license on August 1, 2021.	0 900		

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0 900	Continued From page 21 R1 and R2's records lacked a written contract which included all of the terms concerning the provisions of the following as required: (1) housing (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. In addition, R1 and R2's records lacked evidence that the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated representative. During an interview on November 19, 2021, at 11:30 a.m., R2 stated he had not received a new contract from the licensee. On November 19, 2021, at 12:45 p.m., owner (O)-B stated none of the residents had signed a new contract for the new assisted living licensure requirements, effective August 1, 2021. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided.	0 900		

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0 900	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide orientation to assisted living facility statutes included all the required content for two of two unlicensed personnel ((ULP)-A and ULP-D) with personnel files 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A started employment on February 1, 2017, under the comprehensive home care license and	01460		

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01460	Continued From page 23 began providing assisted living services on August 1, 2021. During an observation on November 17, 2021, at approximately 10:45 a.m., ULP-A provided personal cares to R1 in his room. ULP-D started employment on July 16, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-A and ULP-D's employee records lacked evidence to indicate the employees received orientation to include the following topics: - an overview of assisted living statutes; - an introduction and review of the licensee's policies and procedures related to the provision of assisted living services by the individual staff person; - the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; - the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; - handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; - consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and - a review of the types of assisted living services the employee will be providing and the licensee's category of licensure.	01460		

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01460	Continued From page 24 During an interview on November 19, 2021, at approximately 11:40 a.m., owner (O)-B acknowledged and verified ULP-A and ULP-D's records lacked training and documentation of orientation to assisted living licensure requirements and regulations. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01460		
01480 SS=F	144G.63 Subd. 3 Orientation to resident Staff providing assisted living services must be oriented specifically to each individual resident and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff providing assisted living services were oriented to each individual resident and the services to be provided to the resident for two of two unlicensed personnel ((ULP)-A and ULP-D) with personnel files 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	01480		

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01480	Continued From page 25	01480		

cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-A started employment on February 1, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-A's personnel file lacked documentation of ULP-A's orientation to each individual resident and their needs prior to providing services.

During an observation on November 18, 2021, at approximately 8:10 a.m., ULP-A administered medications to R1. ULP-A stated R1 receives assistance with medications three times per day and with personal cares.

On November 18, 2021, at approximately 11:00 a.m., ULP-A served a snack to R1. R1 finished eating and started shouting, yelling, and calling out the staff. ULP-A approached R1, forcefully turned and held tight to his wheelchair. ULP-A was unable to redirect R1. The surveyor asked ULP-A if he had been oriented to R1's individualized care plan and services provided. ULP-A stated he had followed someone on the job for three days.

ULP-D started employment on July 16, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021.

ULP-D's personnel file lacked documentation of

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01480	Continued From page 26 ULP-D's orientation to each individual resident and their needs prior to providing services. On November 18, 2021, at approximately 12:25 p.m., licensed practical nurse (LPN)-C stated during "huddle" (a time when the nurses and ULPs review new or changed resident information with staff on that shift), the resident information would be provided to staff working, but no documentation for the review is maintained. LPN-C stated this is the practice for the licensee to ensure information is passed to the oncoming shift, but no documentation would be available to review. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01480		
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01500		

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01500	Continued From page 27 (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and	01500		

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01500	Continued From page 28	01500		

involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.

This MN Requirement is not met as evidenced by:
Based on interview and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees (unlicensed personnel (ULP)-A and ULP-D).

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).

The findings include:

ULP-A started employment on February 1, 2017, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-A's employee record lacked evidence ULP-A received eight hours of annual training.

ULP-D started employment on July 16, 2020, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-D's employee record lacked evidence ULP-A received eight hours of annual training.

ULP-A and ULP-D's records lacked evidence of

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01500	Continued From page 29 annual training to include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated	01500		

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01500	Continued From page 30 age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. On November 18, 2021, at approximately 2:55 p.m., owner (O)-B acknowledged annual training had not been completed for ULP-A and ULP-D or any of the licensee's staff due to Covid-19. O-B stated the licensee had a plan to complete annual training for 2021 for the licensee's employees. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01500		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (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 individualized medication management record for each resident based on the resident's assessment that must contain the following:	01730		

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01730	Continued From page 31 (1) a statement describing the medication management services that will be provided; (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; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (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. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop an individualized medication management record with the required content for one of two residents (R1) with records reviewed.	01730		

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01730	Continued From page 32	01730		

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:

R1's diagnoses included a brain injury.

R1's Service Plan dated June 7, 2018, indicated R1 received medication management services.

R1's prescriber orders dated November 11, 2021, included: lorazepam (a narcotic used to treat anxiety) 0.5 milligram (mg) taken one tablet by mouth twice daily, gabapentin (an anticonvulsant used to treat seizures and nerve pain) 300 mg taken two capsules by mouth twice daily, citalopram (an antidepressant) 20 mg taken one tablet by mouth daily, and trazodone (an antidepressant used to treat insomnia) 50 mg take one half tablet by mouth at bedtime as needed if cannot sleep.

R1's medical record lacked documentation of a medication management plan including:
- a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with manufacturer's directions;
- documentation of specific resident instructions relating to the administration of medications;
- any resident-specific requirements relating to documenting medication administration, verification that all medications are administered

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01730	Continued From page 33 as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions; - identification of medication management tasks that may be delegated to unlicensed personnel; and - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services. During an observation on November 18, 2021, at approximately 9:30 a.m., unlicensed personnel (ULP)-A administered medications to R1. During an interview on November 18, 2021, at approximately 1:30 p.m., licensed practical nurse (LPN)-C acknowledged the required medication management content was missing in R1's record, and they will inform the registered nurse. The licensee lacked policies to include the new assisted living licensure requirements, effective August 1, 2021. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23395	A. BUILDING: _____ B. WING _____	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HOUSE INC	1100 IDAHO AVENUE GOLDEN VALLEY, MN 55427

(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
01890	Continued From page 34 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of expired medications for one of two residents (R2) with record 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: R2's physician orders dated September 17, 2021, indicated R2's prescriptions included: acetaminophen 325 milligrams (mg) by mouth every four hours as needed for pain, amlodipine (an antihypertensive) 5 mg tab by mouth one time a day, metoprolol tartrate (an antihypertensive) 12.5 mg by mouth two times a day, senna-s (a laxative) 8.6 mg tablet by mouth two times a day, allopurinol (a uric acid reduction medication used to treat gout) 300 mg tablet one tablet by mouth daily, and warfarin (a blood thinner) 5 mg tablet take 2.5 mg by mouth every Monday, Wednesday and Friday. During an observation on November 18, 2021, at approximately 9:30 a.m., unlicensed personnel (ULP)-A administered medications to R2. During an observation on November 18, 2021, at approximately 10:00 a.m., R2's medication box	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	23395	A. BUILDING: _____ B. WING _____	11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE HOUSE INC	1100 IDAHO AVENUE GOLDEN VALLEY, MN 55427

(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
01890	Continued From page 35 contained a bottle of acetaminophen (an analgesic for minor aches and pains) 325 mg tablets, which was past the manufacturer's expiration date of June 2021. During an interview on November 18, 2021, at approximately 2:40 p.m., licensed practical nurse (LPN)-C stated all resident medications are labeled, and the nurses check to ensure they are not expired. LPN-C stated she may have missed the expired acetaminophen when she went through the residents' medications to refill. The licensee's undated policy titled, Medication Management, did not address expired medications. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

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

Type: Full
Date: *11/17/21*
Time: 11:31:21
Report: 7958211249

Food and Beverage Establishment Inspection Report

Location:
Hawthorne House Inc
1100 Idaho Avenue
Golden Valley, MN55427
Hennepin County, 27

Establishment Info:
ID #: 0038064
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6123869200
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

LPN STATED THAT THEY DO NOT MAINTAIN AN EMPLOYEE ILLNESS LOG.
MAINTAIN A DOCUMENTED EMPLOYEE ILLNESS LOG AS REQ. BY ABOVE RULE. SEE COMMENTS FOR ADDITIONAL REMARKS.

Comply By: 11/17/21

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

3-302.11A(1) ***** Priority 1 *****

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

RAW SHELL EGGS STORED IN REFRIGERATOR ABOVE READY-TO-EAT FOODS.
DO NOT STORE RAW ANIMAL FOODS ABOVE READY-TO-EAT FOODS. EGGS WERE MOVED TO LOWEST LEVEL.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-703.11C ***** Priority 1 *****

MN Rule 4626.0905C Sanitize food contact surfaces of equipment and utensils after cleaning by using an approved chemical sanitizer in manual or mechanical operations for at least 7 or 10 seconds for chlorine depending on temperature, concentration, and pH; and 30 seconds for all other chemical sanitizers or a contact time used in relation with a combination of temperature, concentration, and pH.

DISH MACHINE DOES NOT HAVE A SANITIZING CYCLE. EITHER REPLACE DISH MACHINE WITH ONE THAT HAS A SANITIZING CYCLE OR AFTER DISHES/UTENSILS/ETC. ARE WASHED/RINSED IN DISH MACHINE, SANITIZE IN BASIN OF KITCHEN SINK. SEE COMMENTS FOR ADDITIONAL REMARKS.

Comply By: 11/17/21

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

FACILITY DOES NOT HAVE A SMALL DIAMETER PROBE THERMOMETER TO CHECK/CONFIRM PROPER COOKING & COLD HOLDING TEMPS. OBTAIN AND MAINTAIN ON-SITE A THERMOMETER AS REQ. BY ABOVE RULE.

Comply By: 12/01/21

5-200C Plumbing: Maintenance, fixture location

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

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

FACILITY DOES NOT HAVE A DEDICATED FOOD SERVICE HAND WASH SINK. DESIGNATE A BASIN OF THE KITCHEN SINK FOR HAND WASHING. ONLY USE THE DESIGNATED BASIN FOR HAND WASHING.

Comply By: 11/17/21

Surface and Equipment Sanitizers

Ambient air temperature: = at 37 Degrees Fahrenheit
Location: Refrigerator
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/Almond milk
Temperature: 34 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

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

INSPECTION WAS CONDUCTED BY GEORGE WAHL IN CONJUNCTION WITH A HEALTH REGULATIONS DIVISION EVALUATION. DISCUSSED WITH MARY JO OLIVER, LPN AT THE FACILITY, THE FOOD SERVICE PROVIDED TO RESIDENTS OF THIS FACILITY. MAXIMUM NUMBER OF RESIDENTS THAT ARE EVER AT THIS FACILITY AT THE SAME TIME IS FOUR. SHE STATED THAT ALL MEALS ARE PROVIDED FOR SAME-DAY SERVICE AND CONFIRMED THAT MEALS ARE NOT EVER PREPARED IN ADVANCE & THEN FROZEN OR HELD COLD FOR SERVICE AT A LATER DATE.

DISCUSSED WITH MARY JO OLIVER THAT FOOD CONTACT SURFACES MUST BE WASHED,

RINSE AND SANITIZED AFTER USE AND BEFORE REUSE. CURRENT HOUSEHOLD DISH MACHINE DOES NOT HAVE A SANITIZING CYCLE. DISCUSSED WITH HER THE FOLLOWING OPTIONS:
1. REPLACE EXISTING DISH MACHINE WITH A UNIT THAT HAS AN APPROVED SANITIZING CYCLE.
2. USE THE CURRENT DISH MACHINE TO WASH AND RINSE DISHES/UTENSILS/ETC. CLEAN AND SANITIZE ONE BASIN OF KITCHEN SINK. FILL BASIN WITH WATER AND ADD BLEACH/CHLORINE TO PRODUCE A SANITIZING SOLUTION WITH A CONCENTRATION BETWEEN 50-75 PPM. WHEN DISH MACHINE CYCLE IS DONE, PLACE ALL ITEMS FROM DISH MACHINE INTO SINK CONTAINING SANITIZER. THEN REMOVE ALL ITEMS FROM SANITIZER SOLUTION, RE-STACK IN DISH MACHINE AND ALLOW ALL ITEMS TO AIR DRY.

FACILITY MGR STATED THAT THEY WOULD IMMEDIATELY USE OPTION 2 TO SANITIZE FOOD CONTACT SURFACES.

KITCHEN IS A TRADITIONAL HOUSEHOLD KITCHEN, FLOORS IS LAMINATED WOOD, WALLS ARE A COMBINATION OF CERAMIC TILE AND PAINTED SURFACES, CEILING HAS A SMOOTH PAINTED FINISH. ALL FINISHED SURFACES ARE IN VERY GOOD CONDITION AND ARE CLEAN.

DISCUSSED WITH MS. OLIVER ALL ORDERS DOCUMENTED IN THIS REPORT. ALSO DISCUSSED HAND WASHING, GLOVE USAGE/ELIMINATION OF BARE HAND CONTACT WITH FOODS, SANITIZING, COOK TIMES AND TEMPERATURES, COOLING AND HOT

REVIEWED THE SYMPTOMS OF FOODBORNE ILLNESSES AND THE REQUIREMENT: TO MAINTAIN A DOCUMENTED RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH EITHER VOMITING OR DIARRHEA AS REQUIRED BY THE MINNESOTA FOOD CODE & TO EXCLUDE ILL WORKERS FROM WORKING WITH FOOD & BEVERAGES UNTIL 24 HOURS AFTER SYMPTOMS HAVE ENDED.

MAINTAINING AN ACCURATE RECORD OF ALL INSTANCES OF EMPLOYEES BEING ILL WITH VOMITING AND/OR DIARRHEA MAY PROVIDE A FIRST INDICATION OF INCREASED RISK OF A FOODBORNE ILLNESS TO PERSONS AS A RESULT OF EATING AT THE FACILITY.

**IF ANY RESIDENT COMPLAINS OF ILLNESS, CONTACT THE MINNESOTA DEPARTMENT OF HEALTH AND PROVIDE THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER TO THE CUSTOMER. THE FOODBORNE ILLNESS HOTLINE PHONE NUMBER IS 1-877-366-3455.

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 7958211249 of 11/17/21.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Signed:_____

Mary Jo Oliver
LPN

Signed:_____

George Wahl, #7958
REHS
MDH - Freeman Building
651-201-4188
george.wahl@state.mn.us