Electronically Delivered

July 2, 2026

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

RE:  Project Number(s) SL39425016

Dear Licensee:

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

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

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL39425016-0<br><br>On June 15, 2026, through June 17, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 148 residents; 69 receiving services under the Assisted Living Facility with Dementia Care license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 485 SS=C | 144G.41 Subdivision 1.a (a) Minimum requirements; required food services | 0 485 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 485 | Continued From page 1<br><br>(a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes.<br><br>This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>On June 15, 2026, at 10:38 a.m., the surveyor observed the menu posted in the facility's common area. Regional clinical director (RCD)-G stated the licensee posted a menu a week in | 0 485 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 485 | Continued From page 2<br>advance in the facility's dining room.<br><br>On June 15, 2026, at 10:45 a.m., the surveyor observed in the licensee's assisted living dining room there was no posted menu. RCD-G asked chef cook (CC)-I if they had a posted week advance menu anywhere in the dining room. CC-I stated they did not have any menu posted in the dining room.<br><br>On June 16, 2026, at 9:45 a.m., R5 stated they were provided with the weekly menu in their apartments but had not seen one posted a week in advance at the facility.<br><br>On June 16, 2026, at 1:36 p.m., RCD-G stated they were not aware the menu was not posted a week in advance in the facility. RCD-G stated they were aware of the requirement.<br><br>The licensee's Meal and Menu Requirements policy, undated, indicated, "menus are prepared at least one week in advance and made available to all residents."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 485 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(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 | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 680 | Continued From page 3<br><br>assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include: | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 680 | Continued From page 4<br><br>The licensee's Emergency Preparedness Program last reviewed August 18, 2025, lacked evidence of the following required content:<br>- program patient population;<br>- subsistence needs for staff and patients;<br>- procedures for tracking of staff and patients;<br>- policies and procedures for volunteers; and<br>- sharing information on occupancy/needs.<br><br>On June 15, 2026, at 2:19 p.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-C stated they were checking if the information was available in their other EPP binders in the facility. On June 17, 2026, at 2:30 p.m., the surveyor requested for any other available information, LALD-C stated they did not have any.<br><br>The licensee's Emergency Preparedness Plan - Appendix Z Compliance policy dated June 30, 2025, indicated the licensee had in place an effective and compliant EPP. The intent was the plan would be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z.<br><br>Minnesota Administrative Rule 4659.0100 Emergency Disaster and Preparedness Plan dated August 11, 2021, indicated assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. The code references documents, specifications, methods, and standards in the State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types.<br><br>No further information was provided. | 0 680 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 0 680 | Continued From page 5<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 01330 SS=D | 144G.60 Subd. 4 (b) Unlicensed personnel<br><br>(b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:<br>(1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform;<br>(2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or<br>(3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two employees (unlicensed personnel (ULP)-D).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and | 01330 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01330 | Continued From page 6<br><br>was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>ULP-G started employment with the licensee on May 3, 2023, to provide assisted living services.<br><br>On June 16, 2026, at 8:00 a.m., the surveyor observed ULP-D administer medications to R2.<br><br>ULP-B's record lacked documentation of training and competency evaluations in the following areas:<br>- documentation requirements for all services provided;<br>- reports of changes in the resident's condition to the supervisor designated by the assisted living provider;<br>- preparation of modified diets as ordered by a licensed health professional;<br>- awareness of confidentiality and privacy;<br>- awareness of commonly used health technology equipment and assistive devices;<br>- observation, reporting, and documenting of resident status;<br>- basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and<br>- recognizing physical, emotional, cognitive, and developmental needs of the resident.<br><br>On June 17, 2026, at 2:30 p.m., regional operations director (ROD)-F stated their older employees were missing some training topics which have since been added to their training plan. ROD-F also stated the missing topics had been covered through their annual training. However, when the surveyor went through | 01330 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01330 | Continued From page 7<br><br>ULP-D's training transcript the topics above were missing.<br><br>The licensee's Staff Training Policy dated July 1, 2025, indicated staff training, knowledge, and skills are essential to providing excellent care to our residents. The policy also indicated all the missing content above would be included in the training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01330 | | |
| 01540 SS=E | 144G.64 (a) (3) Training in Dementia, Mental Illness, and De-<br><br>(3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; | 01540 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01540 | Continued From page 8<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure staff completed at least eight hours of initial dementia training on topics specified under paragraph (b) within 80 working hours of the employment start date for two of three employees (licensed practical nurse (LPN)-E, unlicensed personnel (ULP)-B).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).<br><br>The findings include:<br><br>LPN-E<br>LPN-E was hired and began providing assisted living services on April 4, 2023.<br><br>LPN-E's Training and Competency Checklist - Dementia Care dated November 7, 2024, indicated LPN-E had completed the following dementia training topics for a blanket total of 6 hours:<br>- dementia management and abuse prevention;<br>- explanation of Alzheimer's disease & dementia;<br>- review types of dementia, the journey;<br>- person centered care of a person living with dementia; | 01540 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01540 | Continued From page 9<br>- assistance with activities of daily living;<br>- communication; and<br>- problem solving.<br><br>LPN-E's record lacked time spent for each dementia training up to the required 8 hours within 80 working hours of the employment start date.<br><br>ULP-B<br>ULP-B was hired and began providing assisted living services on January 8, 2024.<br><br>ULP-B's My Transcript dated May 2, 2024, indicated ULP-B had completed 2.25 hours of dementia training in the following topics:<br>- dementia 1 - introduction and overview - 1 hour; and<br>- dementia management and abuse prevention - 1.25 hours.<br><br>ULP-B's Dementia Quiz dated January 11, 2024, indicated ULP-B completed a blanket total of 8 hours of dementia testing for a score of 98%.<br><br>ULP-B's record lacked dementia training in the following topics for a total of 8 hours within 80 working hours of the employment start date:<br>- an explanation of Alzheimer's disease and other dementias;<br>- assistance with activities of daily living;<br>- problem solving with challenging behaviors;<br>- communication skills; and<br>- person-centered planning and service delivery.<br><br>On June 17, 2026, at 1:45 p.m., licensed assisted living director (LALD)-C and regional operations director (ROD)-F stated some employees were missing initial dementia training topics and some had a blanket 8 hours of training. | 01540 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01540 | Continued From page 10<br><br>The licensee's Dementia Care Staff Training policy dated September 11, 2023, indicated initial training will be completed within 80 working hours of the employment start date. The policy also indicated dementia care training will include the following topics:<br>- an explanation of Alzheimer's disease and other dementias;<br>- assistance with activities of daily living;<br>- problem solving with challenging behaviors;<br>- communication skills;<br>- person-centered planning and service delivery;<br>- understanding cognitive impairment;<br>- understanding behavioral and psychological symptoms of dementia; and<br>- standards of dementia care including nonpharmacological dementia care practices that are person-centered and evidence-informed.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01540 | | |
| 01620 SS=E | 144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring<br><br>(a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.<br>(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 | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01620 | Continued From page 11<br>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.<br>(c) Resident reassessment and monitoring must be conducted by a registered nurse:<br>(1) no more than 14 calendar days after initiation of services;<br>(2) as needed based on changes in the resident's needs; and<br>(3) at least every 90 calendar days.<br>(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.<br>(e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.<br>(f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.<br><br>This MN Requirement is not met as evidenced by: | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01620 | Continued From page 12<br><br>Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted resident reassessment and monitoring at least every 90 calendar days for two of four residents (R2, R5).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).<br><br>The findings include:<br><br>R2<br>R2 was admitted to the licensee on June 13, 2025, for assisted living services.<br><br>R2's Service Plan Agreement dated March 31, 2026, indicated R2 received services for medication administration, registered nurse evaluation, housekeeping, activity assistance, remove garbage, housekeeping, linen change, laundry, and safety checks.<br><br>On June 16, 2026, at 8:00 a.m., the surveyor observed ULP-D administer medications to R2.<br><br>R2's record included Master Assessments completed on November 9, 2025, December 21, 2025, and March 27, 2026. The assessment dated March 27, 2026, was completed 6 days late.<br><br>R5 | 01620 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01620 | Continued From page 13<br><br>R5 was admitted to the licensee on June 23, 2025, for assisted living services.<br><br>R5's Service Plan Agreement dated January 18, 2026, indicated R5 received services for medication administration, registered nurse evaluation, housekeeping, activity reminders, bathing assist of one, housekeeping, linen change, laundry, dressing, and safety checks.<br><br>R5's record included Master Assessments completed on January 12, 2026, and June 7, 2026. 146 days passed between the two assessments.<br><br>On June 17, 2026, at 2:30 p.m., clinical nurse supervisor (CNS)-A stated they were aware of the late assessments, but would not give the reason as to why they were late. CNS-A also stated they were not aware of any other residents' assessments completed late.<br><br>The licensee's Initial and Ongoing Nursing Assessments of Residents policy dated August 1, 2021, indicated ongoing assessment would be completed periodically but no less than every 90-days.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01620 | | |
| 01730 SS=F | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01730 | Continued From page 14<br>staff delegated the task by a registered nurse 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:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes.<br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01730 | Continued From page 15<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to accurately maintain an individualized medication management plan (IMMP) to include all required content for four of four residents (R2, R3, R4, R5).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).<br><br>The findings include:<br><br>R2<br>R2 was admitted to the licensee on June 13, 2025, for assisted living services.<br><br>R2's Service Plan Agreement dated March 31, 2026, indicated R2 received services for medication administration, registered nurse evaluation, housekeeping, activity assistance, remove garbage, housekeeping, linen change, laundry, and safety checks.<br><br>On June 16, 2026, at 8:00 a.m., the surveyor observed ULP-D administer medications to R2.<br><br>R3<br>R3 was admitted to the licensee on December 24, 2024, for assisted living services. | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01730 | Continued From page 16<br><br>R3 Service Plan Agreement dated June 16, 2026, indicated R3 received services for medication administration, registered nurse evaluation, glucose check, activity escort, toileting, emergency evacuation assist, insulin administration, housekeeping, activity assistance, remove garbage, housekeeping, linen change, laundry, and safety checks.<br><br>R4<br>R4 Service Plan Agreement dated April 6, 2026, indicated R4 received services for medication administration, registered nurse evaluation, bathing, behavior monitor, dining escort, dressing, oral care, nail care, grooming, blood glucose check, insulin administration, housekeeping, activity assistance, remove garbage, housekeeping, linen change, laundry, and safety checks.<br><br>R5<br>R5 was admitted to the licensee on June 23, 2025, for assisted living services.<br><br>R5's Service Plan Agreement dated January 18, 2026, indicated R5 received services for medication administration, registered nurse evaluation, housekeeping, activity reminders, bathing assist of one, housekeeping, linen change, laundry, dressing, and safety checks.<br><br>R2, R3, R4, and R5's IMMP lacked the following required content:<br>- procedures for staff notifying a registered nurse or appropriately licensed health professional when a problem arises with medication management services.<br><br>On June 17, 2026, at 2:30 p.m., regional clinical director (RCD)-G stated the content was missing | 01730 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01730 | Continued From page 17<br><br>in the residents' record. RCD-G also stated they thought it was posted on the medication carts and provided during training. However, there was no related information in the residents' record.<br><br>The licensee's Individualized Medication, Treatment & Therapy Management Plans policy dated May 24, 2022, indicated RN will develop a treatment and therapy management plan for each resident receiving treatment and/or therapy management services. The treatment and therapy management plan will include:<br>a. statement of the type of service(s) provided;<br>b. documentation of specific resident instructions relating to the treatments and/or therapy administration;<br>c. identification of treatment or therapy tasks that may be delegated to an unlicensed staff member;<br>d. procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments and/or therapy services; and<br>e. 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 and/or therapy to prevent possible complications or adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01890 | Continued From page 18<br><br>by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to discard expired medication for one of four residents (R9). In addition, the licensee failed to ensure medication label included expiration or beyond-use date for two of four residents (R8, R10).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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).<br><br>The findings include:<br><br>On June 17, 2026, at 10:00 a.m., the surveyor observed the following expired and unlabeled expiration date medications in the dementia care unit and the second-floor assisted living medication carts.<br><br>EXPIRED<br><br>R9<br>- hyoscyamine 0.125 milligram (mg) tablet place one tablet under tongue every 4 hours as needed for secretions, expired May 30, 2025; and<br>- prochlorperazine 10 mg tablet take one tablet by | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 39425 | A. BUILDING: _____ B. WING _____ | 06/17/2026 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 01890 | Continued From page 19<br>mouth as needed for nausea, expired May 30, 2025.<br><br>UNLABELED WITH BEYOND USE DATE<br><br>R8<br>- quetiapine 25 mg tablet take one half tablet by mouth once daily as needed for agitation.<br><br>R10<br>- Onelax 10 mg rectal suppository administer one suppository rectally once daily as needed.<br><br>On June 17, 2026, at 2:30 p.m., regional clinical director (RCD)-G stated the licensed practical nurse was responsible for auditing the medication carts. LPN-E stated they had completed all medication cart audits in the previous week. LPN-E aslo stated they had asked ULPs to inform them whenever they noticed medication in the cart near to or expired.<br><br>The licensee's Disposition or Disposal of Medication policy dated January 23, 2023, indicated staff will document the disposition or disposal of medications in the resident's record. The policy lacked the verbiage to include expired medications and beyond-use date labeling.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |

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

# Food & Beverage Inspection Report



**Establishment Info**

Hayden Grove of St. Anthony
2601 STINSON PARKWAY
St Anthony, MN 55418
Hennepin County
Parcel:

Phone:

**License Info**

License: HFID 39425

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

**Inspection Info**

Report Number: F1025261122
Inspection Type: Full - Single
Date: 6/22/2026 Time: 11:30 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

## Food & Beverage General Comment

Facility serviced by contract, Hennepin County license posted in kitchen office. Post a copy with other licenses by front desk, conspicuous to consumers.

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

**I acknowledge receipt of the Metro District Office inspection report number F1025261122 from 6/22/2026**

Establishment Representative

Casey Kipping, MA RS
Public Health Sanitarian 3
651-201-4513
casey.kipping@state.mn.us