DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 14, 2025

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

RE: Project Number(s) SL23395016

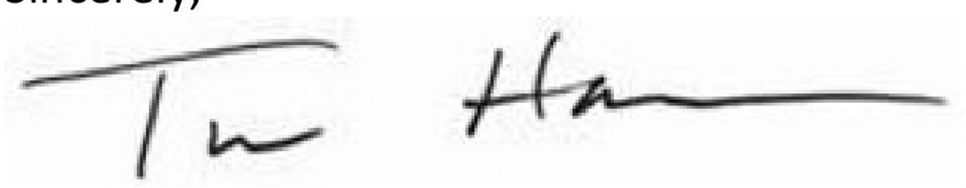
Dear Licensee:

On January 29, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 6, 2024. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



Tim Hanna, Supervisor
State Engineering Services Section
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

HHH

Electronically Delivered

December 17, 2024

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

RE: Project Number(s) SL23395016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 6, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

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 _____	11/06/2024

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 ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL23395016-0 On November 4, 2024, through November 6, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were two residents receiving services under the Assisted Living Facility license. An immediate order was issued on November 5, 2024, for tag identification 0780. During the course of the survey, the licensee failed to take action to mitigate the imminent risk identified in the immediate order and failed to provide requested corrective documentation for the immedate order.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 1 (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 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 (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living with dementia license. Additionally, the licensee failed to post an emergency disaster plan prominently. 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 2 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 facility tour on November 4, 2024, at 11:40 a.m., the surveyor observed one occupied resident room on the main level and one the lower level. The surveyor could not locate the EPP or a posting indicating where the EPP could be found. The surveyor also did not observe an emergency exit diagram on the lower level. On November 4, 2024, at 12:52 p.m., the surveyor asked unlicensed personnel (ULP)-B where the EPP was located so ULP-B went to a lockable kitchen cabinet (cabinet door was unlocked) and searched for the EPP which he was unable to locate. ULP-B stated the EPP was usually located in the locked cabinet with the resident medication administration record (MAR). The surveyor later located the EPP on a shelf near the entry door within the locked office on the lower level. The licensee's emergency disaster preparedness plan dated 2021, lacked evidence of the following required content: - EP testing/annual testing requirements; - procedures for tracking of staff and patients; - policies and procedures for volunteers; - roles under a waiver declared by secretary; and - LTC family notifications. On November 5, 2024, at 1:45 p.m., owner/licensed assisted living director	0 680		

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0 680	Continued From page 3 (O/LALD)-D stated she was informed from a previous survey at another location the EPP needed to be posted prominently but was hesitant because it contained private resident information, so it was locked in the kitchen cabinet. The EPP was recently brought downstairs because the licensee was having the area painted. On November 6, 2024, at 11:20 a.m., O/LALD-D stated she understood the EPP lacked site specific details and lacked the required content listed above. O/LALD-D showed the surveyor she had posted the lower-level exit diagram. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would include all required components of the emergency preparedness plan and posted prominently. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=H	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;	0 780		

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0 780	Continued From page 4 (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: 780 Based on observation and interview, the licensee failed to provide resident sleeping rooms with egress windows in compliance with Minnesota State Fire Code. Per Minnesota State Fire Code provided egress windows did not meet the minimum window opening meeting the minimum state standard for egress. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	0 780	During the course of the survey, the licensee failed to take action to mitigate the imminent risk identified in the immediate order and failed to provide requested corrective documentation.	

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0 780	Continued From page 5 On November 5, 2024, from approximately 10:50 a.m. to 12:00 p.m., the surveyor toured the facility with unlicensed personnel (ULP)-B. During the tour, the surveyor asked ULP-B to open the windows in the resident sleeping rooms for measurement. The noncompliant measurements were as follows: OCCUPIED SLEEPING ROOMS: Resident sleeping room 1: Two windows measuring 27 inches clear width, 20 inches clear height, and 548 square inches total open area for each window. UNOCCUPIED SLEEPING ROOMS: Resident sleeping room 2: Two windows measuring 29.5 inches clear width, 19.5 inches clear height, and 575.25 square inches total open area. Resident sleeping room 3: One window measuring 29.5 inches clear width, 19 inches clear height, and 560.5 square inches total open area. The windows in resident sleeping rooms 2, and 3 did not meet the minimum requirements for opening height. The windows in bedrooms 1, 2, and 3 did not meet the minimum requirements for total openable area. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Surveyor explained to ULP-B that at least one window in each bedroom in a state-licensed	0 780		

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0 780	Continued From page 6 facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. On July 17, 2024, the surveyor explained to ULP-B that an immediate correction order was issued for the above findings. ULP-B stated they understood the requirements for egress windows and would immediately start the process of getting the windows replaced. TIME PERIOD FOR CORRECTION: Immediate	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: 800 Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, 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	0 800		

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0 800	Continued From page 7 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 a facility tour on November 6, 2024, from 10:50 a.m. to 12:38 p.m., with unlicensed personnel (ULP)-B, surveyor observed the following: Low voltage electrical wires were drooping and hanging over the window well for the egress window in resident sleeping room 4, which impeded ability to open the window quickly and easily. These wires also became frayed where they rubbed on the window assembly. The bathroom sink on the main floor had flexible plastic piping installed which replaced existing metal piping. Plumbing must be maintained to an approved condition with approved materials which require a smooth interior. Handle hardware was missing from cabinet doors in basement laundry room, above the clothes dryer. A screw sticking out of the cabinet door and missing the knob which had been attached. Hole was present in the soffit above the rear exit door. The windowsills for resident room 2 and resident room 3 were rotten and deteriorated. During the facility tour interview on November 5, 2024, ULP-B verified the above listed physical environment observations while accompanying the tour.	0 800		

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0 800	Continued From page 8 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
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 the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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0 810	Continued From page 9 This MN Requirement is not met as evidenced by: 810 Based on interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On November 5, 2024, at 12:00 p.m., unlicensed personnel (ULP)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP failed to identify specific fire protection actions for employees. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that employees	0 810		

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0 810	Continued From page 10 should follow in case of a fire or similar emergency. Record review indicated the licensee failed to provide training to residents at least once per year. ULP-B was unable to provide documentation showing any training offered or training scheduled for a future date for residents on the fire safety and evacuation plan. ULP-B requested the surveyor contact information and indicated that owner and licensed assisted living director (O/LALD)-D would send me additional documentation by the end of the day. No further documentation was provided to the surveyor. Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. ULP-B provided documentation indicating that drills were completed on 10/6/21, 1/8/22, 2/10/23, and 2/3/24. The documented drills did not include what time they were preformed, nor which staff were involved. Documentation was not sufficient to indicate that drills were performed at adequate frequency of at least twice per year per shift as required. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. ULP-B failed to provide documentation of staff trainings on the fire safety and evacuation plan. Record review indicated the licensee failed to provide documentation of evacuation plans, or to indicate location and number of resident rooms. ULP-B failed to provide any documentation of basement level rooms or evacuation route. No evacuation maps were posted of the basement	0 810		

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0 810	Continued From page 11 level in the facility nor were they provided in the FSEP. Resident sleeping rooms were not adequately labeled and numbered. During an interview on November 5, 2024, at 12:04 p.m., survey staff explained the requirements for frequency of drills, employee trainings and FSEP documents and ULP-B stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property for one of one resident (R2). 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	0 970		

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	23395	A. BUILDING: _____ B. WING _____	11/06/2024

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

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0 970	Continued From page 12 or has potential to affect a large portion or all of the residents). The findings include: R2 was admitted to the licensee and began receiving assisted living services on June 13, 2022. R2's record included a [Licensee] Assisted Living Contract signed by R2 on June 13, 2022, which read, "Miscellaneous Provisions: Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and other insurance coverages and shall provide evidence of same by copies of binders or policies provided to [licensee] upon request. The resident acknowledges that [licensee] is not an insurer of the resident's person or property. The resident agrees that [licensee] will not be liable to the resident for any personal injury or property damage (including without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident ... unless and to the extent that the injury or damage is caused by the negligence of [licensee] or its employees or agents. The resident hereby releases [licensee] from liability for any personal injury or property damage suffered by the resident ... unless caused by the negligence of [licensee] or its employees or agents." "Indemnification: [Licensee] shall not be liable for any damage or injury to the resident ... or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely by negligence of [Licensee] ... Nothing contained	0 970		

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0 970	Continued From page 13 herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On November 5, 2024, at 2:30 p.m., owner/licensed assisted living director (O/LALD)-D stated R2's contract was their current contract and used for all residents. O/LALD-D was unaware the contract contained a waiver of liability and that it could not be in the contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a	01290		

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01290	Continued From page 14 background study was submitted and received in affiliation with the assisted living license for three of nineteen employees (unlicensed personnel (ULP)-B, ULP-E, ULP-F). 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-B, ULP-E, and ULP-F began employment on September 8, 2022, May 22, 2024, and August 10, 2022, respectively, to provide direct care to the licensee's residents. The licensee's staff schedule dated October 14, 2024, through November 3, 2024, indicated the following: -ULP-B worked on October 14, 15, 16, 21, 22, 23, 28, 29, and 30, 2024 and November 4, 5, and 6, 2024 (observed working throughout the survey); -ULP-E worked on the October 17, 18, 19, 20, 24, 25, 26, 27, 31, 2024, and November 1, 2, 3, 2024; and -ULP-F worked on October 14, 15, 16, 17, 18, 21, 22, 23, 24, 25, 28, 29, 30, 31, 2024, and November 1, 2024. ULP-B's employee record contained a background study dated September 8, 2022, submitted through a different licensee owned by the same owner as the licensee with Health Facility Identification (HFID) 23104; however,	01290		

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01290	Continued From page 15 ULP-B's employee record lacked evidence the licensee affiliated a background study under the licensee's HFID 23395. On November 6, 2024, at 10:00 a.m., owner/licensed assisted living director (O/LALD)-D pulled up the NETStudy 2.0 roster on their computer as requested. The roster indicated both ULP-B and ULP-F were affiliated to this licensee on November 5, 2024 (after initiation of the survey), and ULP-E was affiliated to licensee on November 6, 2024 (after initiation of the survey). The licensee's Recruitment and Hiring policy effective August 1, 2021, indicated the employment process included a criminal background check would be submitted to Minnesota Department of Human Services (DHS). The policy lacked direction that the background study must be affiliated with the licensee, as required. The Minnesota Department of Health (MDH) document titled Resources & Frequently - Asked Questions (FAQs) last updated October 15, 2024, read, "If you have an existing background study for someone at one facility, you can affiliate the person's background study to another facility if the Sensitive Information Person (SIP) is the same." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01560 SS=C	144G.64 (a, b, c) TRAINING IN DEMENTIA CARE REQUIRED	01560		

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01560	Continued From page 16 (5) new employees may satisfy the initial training requirements by producing written proof of previously completed required training within the past 18 months. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and other dementias; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; (4) communication skills; and (5) person-centered planning and service delivery. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, a description of the dementia care training program, the categories of employees trained, the frequency of training, and the basic topics covered. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	01560		

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01560	Continued From page 17 On November 6, 2024, at 9:35 a.m., owner/licensed assisted living director (O/LALD)-D stated the licensee did not have a description of the dementia training program available but would create one. The licensee's Notifications policy effective August 1, 2021, indicated the licensee shall make available to residents in written or electronic form, a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01560		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan	01640		

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01640	Continued From page 18 must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to execute a signed service plan to include services being provided by the licensee for one of one resident (R2). The licensee also failed to ensure the current service plan included a signature or other authentication by the licensee to document agreement on the services to be provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R2 R2 was admitted to the licensee on June 13, 2022. R2's diagnoses included dementia, cognitive deficits, and bilateral (both) knee pain. R2's [Licensee] Home Health Aide Care Plan signed by clinical nurse supervisor (CNS)-A on May 13, 2024, and reviewed by CNS-A on October 18, 2024. The care plan indicated R2 received services for medication administration,	01640		

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01640	Continued From page 19 dressing, grooming, toileting, mobility, personal laundry, housekeeping, and behavior management. The care plan was not signed by R2 and/or R2's designated representative. R2's record lacked a service plan which included the agreement of services the licensee would provide to the resident while including all required content. On November 5, 2024, at 8:35 a.m., unlicensed personnel (ULP)-B administered medications to R2 and provided breakfast. On November 5, 2024, at 11:06 a.m., CNS-A explained she would update the care plan when services were added or revised. Her procedure was to go over the care plan with the resident and/or their designated representative, but since R2's listed designated representative had not been available, CNS-A stated R2 could not sign for himself due to his diagnoses so she didn't know who to go to for signatures. CNS-A was unable to locate R2's initial service plan from admission and said to ask owner/licensed assisted living director (O/LALD)-D where it was kept. On November 5, 2024, at 1:45 p.m., O/LALD-D stated a registered nurse (RN) always filled out a service plan when a resident was admitted and that she was not the one that completed it. She begun looking around to locate the service agreement. R1 R1 was admitted to the licensee on December 27, 2022, and was discharged on August 26, 2024.	01640		

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01640	Continued From page 20 R1's undated Exhibit 2: Service Plan signed by CNS-A lacked a signature by R1 and/or R1's designated representative. On November 6, 2024, at 11:40 a.m., O/LALD-D stated she could not locate R2's service plan and found R1's service plan was not signed by R1 and didn't know why. She said it was the RN's responsibility to make sure they were completed and signed. The licensee's Service Plan policy effective August 1, 2021, indicated: "2. The service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring." And "4. The initial service plan and any revisions are signed by a representative from [Licensee] and the resident or resident's representative, indicating agreement with the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 21 assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	01650		

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01650	Continued From page 22 situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on June 13, 2022. R2's diagnoses included dementia, cognitive deficits, and bilateral (both) knee pain. R2's [Licensee] Home Health Aide Care Plan signed by clinical nurse supervisor (CNS)-A on May 13, 2024, and reviewed by CNS-A on October 18, 2024. The care plan indicated R2 received services for medication administration, dressing, grooming, toileting, mobility, personal laundry, housekeeping, and behavior management. R2 medical record lacked a service plan to include the following: - the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; - the identification of staff or categories of staff who will provide the services; - the schedule and methods of monitoring staff providing services; and - a contingency plan that includes: a. the action to be taken if the scheduled service cannot be provided; b. information and a method to contact the facility; c. the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and d. the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made	01650		

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01650	Continued From page 23 by the resident under those chapters. On November 5, 2024, at 8:35 a.m., unlicensed personnel (ULP)-B administered medications to R2 and provided breakfast. On November 5, 2024, at 11:06 a.m., CNS-A was unable to locate R2's initial service plan from admission and said to ask owner/licensed assisted living director (O/LALD)-D where it was kept. On November 5, 2024, at 1:45 p.m., O/LALD-D stated a registered nurse (RN) always filled out a service plan when a resident was admitted and that she was not the one that completed it. She begun looking around to locate the service agreement. On November 6, 2024, at 11:40 a.m., O/LALD-D stated she could not locate R2's service plan and confirmed it was missing the required content information. The licensee's Service Plan policy effective August 1, 2021, indicated the service plan would include a description of the services provided, fees for the services, frequency of each service, identification of staff who would provide the service, and a contingency plan. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan	01730		

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01730	Continued From page 24 (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: (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	01730		

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01730	Continued From page 25 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 (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on November 4, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services for all of licensee's residents. On November 5, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 while sitting at the dining room table. R2 was admitted to the licensee on June 13, 2022. R2's diagnoses included dementia, cognitive deficits, and bilateral (both) knee pain. R2's [Licensee] Home Health Aide Care Plan signed by CNS-A on May 13, 2024, and reviewed by CNS-A on October 18, 2024. The care plan	01730		

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01730	Continued From page 26 indicated R2 received medication administration assistance. R2's record lacked a service plan. R2's medication administration record (MAR) dated November 1, 2024, through November 4, 2024, indicated R2's medications included a mild pain reliever (both oral and topical), an anti-depressant, an anti-psychotic, a supplement, a blood thinner (helps prevent blood clot), a stool softener, and a medication to decrease high cholesterol. R2's record lacked a medication management plan to include the following required content: -identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; -identification of medication management tasks that may be delegated to unlicensed personnel; -procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and -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. On November 5, 2024, at 1:15 p.m., owner/licensed assisted living director (O/LALD)-D stated the registered nurse always completed a service plan (including the medication management plan) upon admission but was unable to locate the service plan to include the missing information.	01730		

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01730	Continued From page 27 The licensee's Service Plan for Medication Management policy effective August 1, 2021, indicated [Licensee] would prepare and document a medication management plan as part of the service plan for each resident receiving medication management services that would include the missing required content stated above. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were transcribed and administered as prescribed for one of one resident (R2).	01760		

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01760	Continued From page 28 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: During the entrance conference on November 4, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services for all of licensee's residents. R2's diagnoses included dementia, cognitive deficits, and bilateral (both) knee pain. R2's [Licensee] Home Health Aide Care Plan signed by clinical nurse supervisor (CNS)-A on May 13, 2024, and reviewed by CNS-A on October 18, 2024. The care plan indicated R2 received medication administration assistance. On November 5, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 while sitting at the dining room table. R2's prescriber orders dated July 30, 2024, ordered Seroquel 25 milligram (mg) tablet (for mental/mood disorders)-give two tablets by mouth every day as needed (PRN). R2's medication administration record (MAR) for the months of October and November 2024, indicated Seroquel was not transcribed to the	01760		

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01760	Continued From page 29 MAR. On November 5, 2024, at 10:10 a.m., CNS-A stated the PRN Seroquel order was a current order and was supposed to be on the MAR. The PRN Seroquel was initially ordered on January 10, 2024, and signed and dated January 11, 2024, by CNS-A. CNS-A did not know why she did not transcribe the order on the January MAR but it was on the February MAR. CNS-A stated the nursing staff would inform owner/licensed assisted living director (O/LALD)-D of new orders so they can add it to the MAR by typing it up and printing it out. CNS-A showed the surveyor a bubble pack containing Seroquel 25 mg tablet and each bubble (30 bubbles) had two tablets each. Of the 30 bubbles, the foil was broken on three bubbles potentially indicating three doses were provided. The licensee's Medication Orders policy effective August 1, 2021, indicated [Licensee] will administer medications as prescribed by the authorized prescriber and when a written or electronic prescription is received, it must be communicated to the registered nurse in charge and recorded or placed into the resident's clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed	01790		

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01790	Continued From page 30 nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of	01790		

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01790	Continued From page 31 medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. The deficient practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	01790		

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01790	Continued From page 32 During the entrance conference on November 4, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services for all of the licensee's residents. On November 5, 2024, at 8:40 a.m., after ULP-B administered medications to R2, the surveyor asked ULP-B if there were written procedures available for unplanned time away, and ULP-B stated there were no procedures available to them. On November 5, 2024, at 11:08 a.m., the surveyor requested to view the licensee's written procedures and CNS-A referred the surveyor to a policy which indicated there would be written procedures available. CNS-A stated she did not have one, but to ask the licensee if they had one. On November 5, 2024, at 2:30 p.m., owner/licensed assisted living director (O/LALD)-D stated there were written procedures available at another licensee owned by the same owner, but not for this licensee. O/LALD-D also referred the surveyor to the policy which indicated there would be written procedures available. On November 6, 2024, at 10:00 a.m., O/LALD-D affirmed they did not have written procedures available for this licensee and would have CNS-A create one. At 10:28 a.m., during unlicensed personnel (ULP)-B record review, they provided a "Protocol For Medications Away From Home," which was blank document signed by ULP-B and dated September 16, 2022. O/LALD-D asked if this form could be used for written procedures. The licensee's Medication Management Plan for Residents Away from Home policy effective	01790		

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01790	Continued From page 33 August 1, 2021, indicated the RN had developed written procedures/protocols for the ULPs, including special instructions regarding controlled substances, including: - the type of container(s) to be used for the medications appropriate to the facility's medication system; - how the container(s) should be labeled; - written information about the medications to be provided; - documentation requirements including date medications were provided, who received the medications, who provided the medications to the resident, the number of medications that were provided to the resident, and any other information; - how the RN should be notified that the medications were provided and whether the RN should be notified before the medications are given to the resident or the designated representative; and -medications may be set up for the length of the anticipated absence, not to exceed seven (7) calendar days. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01810 SS=D	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the	01810		

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01810	Continued From page 34 medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure over-the-counter (OTC) drugs were stored as appropriate for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 was admitted to the licensee on June 13, 2022. R2's diagnoses included dementia, cognitive deficits, and bilateral (both) knee pain. R2's assessment dated June 13, 2022, indicated the licensee would store all the medications in a locked cabinet and resident would not have access to medications. On November 5, 2024, at 9:00 a.m., the surveyor observed a tube of Voltaren gel (reduces pain and inflammation in joints) on R2's portable caddy near the entrance of the room. Unlicensed personnel (ULP)-B stated the gel was used for R2's knees and had always been stored in the caddy. ULP-B had not noticed R2 use it on his own.	01810		

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01810	Continued From page 35 On November 5, 2024, at 1:15 p.m., ULP-B stated upon hire, he was trained by a registered nurse (RN) how to administer medications and was checked off by RN to perform that task. R2's medication administration record (MAR) dated November 1, 2024, through November 4, 2024, indicated to apply Voltaren gel 1% to both knees four times a day. On November 5, 2024, at 11:06 a.m., clinical nurse supervisor (CNS)-A stated all of R2's medications were supposed to be locked up because R2 would not know how to use it. The licensee's Storage/Control of Medications policy effective August 1, 2021, indicated when [licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810		
01900 SS=F	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01900		

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01900	Continued From page 36 review, the licensee failed to ensure the prescription drug supply for one of one resident (unknown resident) was not saved for use by anyone other than the resident for which the medication was prescribed. The deficient practice had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: During the entrance conference on November 4, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services for all of the licensee's residents. On November 5, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 while sitting at the dining room table. On November 5, 2024, at 10:10 a.m., the surveyor and CNS-A went through R2's medication bin which contained both scheduled and as needed (PRN) medications. The surveyor pulled out a bubble pack with a label at the top with the following information: -unknown resident's name that was crossed off with a pen and R2's name written next to it, -medication name (loperamide-anti-diarrheal), -dose (2 milligram capsule-27 capsules),	01900		

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01900	Continued From page 37 -instructions for administration, -dispensed date (was crossed off), -expiration date (was crossed off), and -prescription number (RX) (was crossed off). CNS-A stated use of someone's medication for another person was not allowed and that licensed practical nurse (LPN)-C was responsible for managing the residents' weekly medication set up, checking for expired medications, and ordering refills. CNS-A stated LPN-C was new to the assisted living requirements because he/she used to work at the jail for many years. The licensee's Medication Administration policy effective August 1, 2024, indicated no prescription drug supply for one resident may be used or saved for use by anyone other than the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances.	01910		

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01910	Continued From page 38 (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. 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). 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 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: During the entrance conference on November 4, 2024, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services for all of the licensee's residents. On November 5, 2024, at 8:35 a.m., the surveyor observed unlicensed personnel (ULP)-B administer medications to R2 while sitting at the dining room table. R2's diagnoses included dementia, cognitive deficits, and bilateral (both) knee pain. R2's [Licensee] Home Health Aide Care Plan	01910		

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01910	Continued From page 39 signed by CNS-A on May 13, 2024, and reviewed by CNS-A on October 18, 2024. The care plan indicated R2 received medication administration assistance. On November 5, 2024, at 10:10 a.m., the surveyor and CNS-A went through R2's medication bin which contained both scheduled and as needed (PRN) medications. R2's medication bin included the following medications: -propranolol 20 milligram (mg) tablet PRN for anxiety, quantity 30 tablets (expired on September 10, 2024); -quetiapine 25 mg tablet PRN for depression, quantity 54 tablets (expired June 12, 2024); and -quetiapine 50 mg half tablet PRN, quantity approximately 30 ½ tablets (expired September 14, 2023). CNS-A stated licensed practical nurse (LPN)-C was responsible for managing the residents' weekly medication set up, checking for expired medications, and ordering refills. CNS-A stated LPN-C was new to the assisted living requirements because he/she used to work at the jail for many years. LPN-C was unavailable for interview. The licensee's Disposition and Disposal of Medications policy effective August 1, 2021, indicated any medication under [Licensee's] storage after the termination of the medication management program for a resident, that are discontinued or expired or upon a resident's death will be disposed of by a licensed nurse. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7)	01910		

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 _____	11/06/2024

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
01910	Continued From page 40 days	01910		

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

Type: Full
Date: *11/04/24*
Time: 15:09:29
Report: 8058241283

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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: SANITIZER DIP
Violation Issued: No

Food and Equipment Temperatures

Process/Item: POTATO SALAD
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: COOLER
Violation Issued: No

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

HRD INSPECTOR: ANNA BOHNEN

RESIDENTIAL HOME WITH NON-COMMERCIAL APPLIANCES AND FINISHES

SANITIZER MIXED AND TESTED SURING INSPECTION TO 100 PPM CL

Type: Full
Date: *11/04/24*
Time: 15:09:29
Report: 8058241283
Hawthorne House Inc

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 8058241283 of 11/04/24.

Certified Food Protection Manager: ANN KVELLAND

Certification Number: 71067 Expires: 12/20/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
BARBARA BLACKWOOD
SUPERVISOR

Signed: _____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us