Electronically Delivered

September 14, 2022

Administrator
Maple Grove House
10245 94th Avenue North
Maple Grove, MN 55369

RE: Project Number(s) SL37646015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on August 24, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

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

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

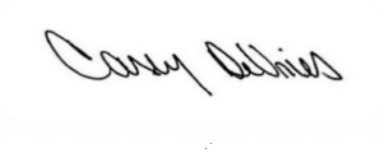
A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

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

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

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

Sincerely,



Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
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Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37646	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HOUSE	10245 94TH AVENUE NORTH MAPLE GROVE, MN 55369

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37636015-0 On August 22, 2022, through August 24, 2022, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. 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 subd. 1, 2, and 3.	
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required	0 110		

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the director of record for the licensee with the Board of Executives for Long-Term Services and Support. This had the potential to affect all of the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Registered nurse (RN)-A obtained an assisted living director license on June 3, 2021. On August 22, 2022, at approximately 9:20 a.m., during the entrance conference, RN-A identified themself as the LALD for the licensee. On August 22, 2022, at 9:21 a.m., the surveyor observed the Board of Executives for Long-Term Services and Support (BELTSS) website which indicated RN-A held a current assisted living director license but was not listed as Director of Record for the licensee.	0 110		

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0 110	Continued From page 2 On August 22, 2022, at 9:24 a.m., RN-A verified they were not listed as the Director of Record for the licensee. RN-A stated the LALD application requested the location of RN-A's employment. In addition, RN-A stated they believed BELTSS would assign the facility location to them and did not know they needed to enter the information. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was	0 480		

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0 480	Continued From page 3 prepared according to the Minnesota Food Code. This 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 potential to affect a large portion or all of the residents). The findings include: Please refer to the additional documentation included in the Food and Beverage Establishment Inspection Reports, dated August 23, 2022. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced	0 630		

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0 630	Continued From page 4 by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnosis included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), seizures, depression and chronic obstructive pulmonary disease. R3's Service Plan - Wavier, dated April 20, 2022, indicated R3's services included medication management. R3's Assessment dated May 31, 2022, indicated R3 was not at risk to be abused by others and R3 was verbally aggressive. The IAPP lacked the following: - the person's risk of abusing other vulnerable adults; and - statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 22, 2022, at approximately 1:03 p.m.,	0 630		

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0 630	Continued From page 5 registered nurse (RN)-A verified the IAPP lacked the content listed above. RN-A stated staff knew how to intervene if R3 showed abusive behaviors towards others however, the assessment lacked documentation of interventions. The licensee's undated Abuse Prevention Plan policy indicated all clients [residents] would be assessed for their risk of abusing other vulnerable adults and would develop a statement of the specific measures to be taken to minimize the risk of abuse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff	0 680		

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0 680	Continued From page 6 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 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 license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's emergency disaster preparedness plan lacked evidence of the following required content: - EPP reviewed and updated annually; - current, all-hazards approach facility assessment; - a description of the population served by the licensee; - emergency official contact information including the MN Office of Ombudsman; and	0 680		

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0 680	Continued From page 7 - emergency prep testing requirements. On August 22, 2022, at approximately 12:12 p.m., registered nurse (RN)-A verified the EPP lacked the above content. RN-A stated the licensee completed fire drills and would complete a drill to test the EPP in the future. In addition, RN-A stated the licensee's all-hazard approach facility assessment may be located at a different facility. Although requested, the surveyor did not receive a copy of the licensee's all-hazard approach facility assessment. The licensee's undated Emergency Management Policy indicated the licensee would have and identified plan in place to ensure the safety and well-being of clients [residents] and employees during periods of and emergency or disaster that disrupts services. In addition, the employees would participate in and annual drill to determine the effectiveness and efficiency of the current plan and any forms developed for use in a disaster. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 780 SS=F	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	0 780		

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0 780	Continued From page 8 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (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: Based on observation and interview, the licensee failed to maintain smoke alarms in the facility. 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, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On August, 24 2022 between 2:15 PM to 3:00 PM, survey staff observed that the smoke alarm located in the hallway near the sleeping rooms	0 780		

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0 780	Continued From page 9 was missing. Unlicensed personnel (ULP)-D verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility fire extinguishers. This had the potential to affect all current 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	0 790		

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0 790	Continued From page 10 or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 24, 2022 between 2:15 PM to 3:00 PM, survey staff toured the facility with the Unlicensed personnel (ULP)-D. During the facility tour, staff observed that the fire extinguisher on the lower level did not have an inspection tag showing that it had been inspected. ULP-D verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
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: 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 and staff.	0 800		

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0 800	Continued From page 11 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on August 24, 2022 between 2:15 PM to 3:00 PM, survey staff toured the facility with Unlicensed personnel (ULP)-D. During the facility tour, survey staff observed the following: 1. The toilet on the main level was not secured to the floor. 2. The door handle was missing on the door that leads from the laundry room to the outside. ULP-D verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of:	0 900		

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0 900	Continued From page 12 (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of two residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 900		

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	37646	A. BUILDING: _____ B. WING _____	08/24/2022

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0 900	Continued From page 13 resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 admitted for services on January 20, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's unsigned Service Plan -Wavier dated July 14, 2021, indicated R1 received assistance with appointments, ambulation, meals, toileting, dressing, grooming, behavior management, medication management, nonmedical transportation, shopping and therapeutic exercises. R1's record included an incomplete Housing with Services Lease / Contract. The Housing with Services Lease / Contract did not have any fill in the blank spots filled in by the licensee and lacked signatures from the licensee and resident or resident representative. In addition, the resident records lacked evidence the contract had been fully executed as the facility must: - offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; - give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed; and - the facility must offer the resident the opportunity to identify a designated	0 900		

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0 900	Continued From page 14 representative. On August 22, 2022, at 12:49 p.m., registered nurse (RN)-A verified R1's record lacked a written contract. RN-A stated R1 was unable to sign contract due to cognitive status and the licensee was waiting on a guardian to sign admission paperwork. The surveyor inquired why contract had not been signed by guardian since resident was appointed the guardian in 2021. RN-A stated R1's guardian was difficult to get ahold of. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 950 SS=F	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable."	0 950		

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0 950	Continued From page 15 (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing with the required statutory language for one of two residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R3 admitted for assisted living services on April 20, 2022. R3's Resident Agreement Assisted Living was signed on April 20, 2022. R3's Assisted Living Contract lacked the opportunity to designate a representative and the verbatim "right to designate a representative for	0 950		

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0 950	Continued From page 16 certain purposes" notice. On August 23, 2022, at approximately 12:12 p.m., registered nurse (RN)-A, and manager (M)-C verified R3's contract lacked the verbatim "right to designate a representative for certain purposes" notice. RN-A stated staff asked residents if they wanted to designate a representative. M-C stated all contracts would not contain the verbatim "right to designate a representative for certain purposes" notice. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 17 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one or one resident (R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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).	01060		

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01060	Continued From page 18 The findings include: R2 admitted for assisted living services on February 24, 2022. R2's Service Plan - Wavier signed February 24, 2022, indicated R2 received services for meals, toileting, dressing, grooming, home management, medication administration and nonmedical transportation. R2's Resident Notes dated April 29, 2022, to August 23, 2022, indicated the licensee sent R2 to the University of Minnesota Hospital on August 1, 2022, for low oxygen levels and R2 had not returned to the facility. R2's record lacked a written notice that contains, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R2's record lacked notification to the Office of Ombudsman for Long-Term Care with in four days that R2 had been relocated and had not returned to the facility.	01060		

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01060	Continued From page 19 On August 23, 2022, registered nurse (RN)-A stated the licensee updated the case manager on hospitalization however, lacked documentation of conversation. In addition, RN-A stated the licensee was unaware of the requirement listed above. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01060		
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 background study was submitted and received for two of two employees (registered nurse (RN)-A, and unlicensed personnel (ULP)-B) with records	01290		

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01290	Continued From page 20	01290		

reviewed.

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

The findings include:

RN-A
RN-A was hired December 1, 2017, to provide direct care and services to the licensee's residents and supervise the licensee's employees under the comprehensive license. RN-A began providing services under the licensee's assisted living license on August 1, 2021.

RN-A's employee record contained a background study clearance letters, submitted by separate locations also operated by the licensee's owner, dated November 20, 2017, August 23, 2019, March 26, and May 4, 2021. RN-A's employee record lacked evidence the licensee submitted a background study for the licensee's location.

ULP-B
ULP-B was hired June 3, 2022, to provide direct care and services to the licensee's residents.

On August 23, 2022, at between 8:30 a.m., and 9:00 a.m., the surveyor observed ULP-B administer oral medications to R1 and R2.

ULP-B's employee record contained a background study clearance letter, submitted by a separate location also operated by the licensee's

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01290	Continued From page 21 owner, dated June 22, 2022. ULP-B's employee record lacked evidence the licensee submitted a background study for the licensee's location. On August 22, 2022, at approximately 11:07 a.m., RN-A stated the licensee did not know the background check needed to be completed for specific locations. Manager (M)-C stated when the licensee completed a background check on all employee's the location and HFID for the licensee was not an option to choose from. In addition, M-C stated they would contact the company to have the location and HFID added so the licensee could conduct new background studies. The licensee's undated Background Studies policy indicated the licensee required background screenings to be completed on all employees. In addition, all employees would not be able to start working with clients [residents] until the background check clearance had been received. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days.	01290		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living	01620		

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01620	Continued From page 22 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. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) completed a 14-day reassessment not to exceed 14 days for one of two residents (R3) and ongoing resident reassessments did not exceed 90 days for one of two residents (R1) as required with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R1 R1 admitted for services on January 20, 2019,	01620		

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	37646	A. BUILDING: _____ B. WING _____	08/24/2022

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01620	Continued From page 23 under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's unsigned Service Plan -Wavier dated July 14, 2021, indicated R1 received assistance with appointments, ambulation, meals, toileting, dressing, grooming, behavior management, medication management, nonmedical transportation, shopping and therapeutic exercises. R1's record indicated the RN completed ongoing assessments on February 10, 2022, May 18, 2022, and July 14, 2022, which indicated 97 days passed between February and May assessments. R3 R3 admitted for assisted living services on April 20, 2022. R3's Service Plan - Wavier signed April 20, 2022, indicated R3 received medication administration four times per day. R3's record indicated the RN completed an admission assessment on April 20, 2022, and a 14-day assessment on May 6, 2022, which indicated 16 days passed between assessments. On August 23, 2022, at 12:13 p.m., RN-A verified R1's ongoing assessment exceeded 90 days and verified R3's 14-day assessment exceeded 14 days. RN-A stated the RN relied on the computer system for a reminder on when to complete assessments. In addition, RN-A stated assessment being completed late was an "oversite." The licensee's undated Comprehensive Client	01620		

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01620	Continued From page 24 Assessment policy indicated a reassessment must be conducted in the clients [residents] home no more than 14 days after initiation of services and ongoing monitoring and reassessments cannot exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01620		
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 25 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 a signature or other authentication by the resident or responsible party and the facility to document agreement on the services to be provided for one of two residents (R1). In addition, the licensee failed to revise the service plan to reflect a description of the services to be provided for one of two residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 admitted for services on January 20, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. On August 22, 2022, at approximately 10:32 a.m., registered nurse (RN)-A provided the surveyor with a document titled Service Plan -Wavier dated July 14, 2021, which RN-A indicated was the service plan for R1. RN-A stated R1's service plan was not signed due to R1's cognitive status and the licensee would have the guardian sign the service plan in the future. On August 22, 2022, at 12:56 p.m., RN-A verified R1's record lacked a signed service plan.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01640	Continued From page 26 On August 23, 2022, at approximately 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R1. R3 R3 admitted for assisted living services on April 20, 2022. R3's Assessment date of May 31, 2022, indicated R3 needed assist of two for bathing, assist of one with dressing, assist of one with eating, assist of one with grooming, assist of one with mobility, assist of one of one as needed (PRN) for toileting, housekeeping, laundry, transportation, and assistance with medication management. R3's Service Plan - Wavier signed April 20, 2022, indicated R3 received medication administration four times per day. R3's service plan lacked an updated description to include all of the other services to be provided. On August 23, 2022, at approximately 7:59 a.m., the surveyor observed unlicensed personnel (ULP)-B prepare oatmeal and eggs for R3. On August 23, 2022, 2022, at approximately 8:09 a.m., ULP-B stated R3 required assistance with all cares because of cognition. On August 23, 2022, at approximately 8:11 a.m., the surveyor observed ULP-B empty R3's urinal, supervise dressing, assist with ambulation, transfers, and apply R3's smoking apron. On August 23, 2022, at approximately 8:47 a.m., the surveyor observed ULP-B administer oral medications to R3.	01640		

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	37646	A. BUILDING: _____ B. WING _____	08/24/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE GROVE HOUSE	10245 94TH AVENUE NORTH MAPLE GROVE, MN 55369

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01640	Continued From page 27 On August 23, 2022, at approximately 12:04 p.m., RN-A stated the licensee did not know once a rate or service was added to a service plan it would need to be signed by the resident or resident representative. In addition, RN-A stated the resident's representatives are updated verbally when a change was made to the care plan. The licensee's undated Service Plan policy indicated the service plan would be developed with all clients [residents] no later than 14 days after service and must include a signature or other authentication by the home care [assisted living], and by the client [resident] or representative. In addition, the service plan would include serviced to be furnished according to the clients [residents] current assessments. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01640		
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes:	01650		

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01650	Continued From page 28 (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 two residents (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3 admitted for assisted living services on April 20, 2022. R3's Service Plan - Wavier signed April 20, 2022,	01650		

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01650	Continued From page 29 indicated R3 received medication administration four times per day. R3's service plan lacked fees for service for R3. On August 23, 2022, at approximately 8:47 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications to R3. On August 23, 2022, at approximately 12:04 p.m., registered nurse (RN)-A verified R3 service plan lacked fees for service. RN-A stated all residents service plans who were under a waivered service would lack the fees for service until a rate was received by the case worker. In addition, RN-A stated the licensee did not know once a rate or was added to a service plan it would need to be signed by the resident or resident representative. The surveyor inquired why they did not indicate the type of wavier used for payment on signed service plan. RN-A stated the licensee did not know about the requirement. The undated Service Plan policy indicated the service plan would include fees of services. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	01650		
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The	01730		

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	37646	A. BUILDING: _____ B. WING _____	08/24/2022

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01730	Continued From page 30 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 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and	01730		

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01730	Continued From page 31	01730		

maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R3) with records reviewed.

This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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:

R1
R1 admitted for services on January 20, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021.

R1's diagnosis included paranoid schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), traumatic brain injury, dementia, suicide attempt by substance overdose, attention deficit hyperactivity disorder, hypertension, polysubstance dependence, major neurocognitive disorder and antisocial personality disorder.

R1's unsigned Service Plan -Wavier dated July 14, 2021, indicated R1 received assistance with appointments, ambulation, meals, toileting, dressing, grooming, behavior management, medication management, nonmedical transportation, shopping and therapeutic exercises.

R1's Medication list dated August 22, 2022,

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01730	Continued From page 32	01730		

included acetaminophen 500 milligrams (mg), amlodipine 5mg, divalproex 125 mg, ferrous sulfate 325 mg, fluticasone 50 micrograms (mcg), oxybutynin extended release (ER) 5 mg, MiraLAX 17 grams (g), risperidone 2 mg, trazodone 50 mg, vitamin D3 1000 units (IU), deep sea nasal spray 0.65 percent (%), and naproxen sodium 220 mg.

On August 23, 2022, at approximately 8:59 a.m., the surveyor observed unlicensed personnel (ULP)-B administer oral medications crushed and in apple sauce to R1.

R1's Individualized Medication Management plan dated August 3, 2022, lacked documentation of specific resident instructions relating to the administration of medications.

R3
R3 admitted for assisted living services on April 20, 2022.

R3's diagnosis included schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), seizures, depression, and chronic obstructive pulmonary disease.

R3's Assessment date of May 31, 2022, indicated R3 needed assist of two for bathing, assist of one with dressing, assist of one with eating, assist of one with grooming, assist of one with mobility, assist of one of one as needed (PRN) for toileting, housekeeping, laundry, transportation, and assistance with medication management.

R3's Medication list dated May 31, 2022, included carbamazepine ER 300 mg, vitamin D3 1000 IU, clozapine 50 mg, vitamin B12 1000 mcg, famotidine 20 mg, fenofibrate 160 mg, folic acid

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01730	Continued From page 33 400 mcg, magnesium oxide 400 mg, pyridoxine 25 mg, quetiapine 300 mg, venlafaxine 50 mg, Tylenol 500 mg, and nicotine gum 2 mg. On August 23, 2022, at approximately 8:47 a.m., the surveyor observed ULP-B administer oral medications floating in applesauce to R3. R3's Individualized Medication Management Plan dated April 18, 2022, lacked the following: - documentation of specific resident instructions relating to the administration of medications; - a description of storage of medications based on the residents needs and preferences, risk of diversion, and consistent with the manufacturer's directions; and - identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis. On August 23, 2022, at 12:58 p.m., registered nurse (RN)-A verified R1 and R3's record lacked the above content. RN-A stated RTasks (a software documenting system) would prompt nurses to enter information for the individualized medication management plan. In addition, RN-A stated R1 and R3's information had been missed on data entry. The licensee's undated Individualized Medication Management Plan and Record policy indicated the above content would be included in the individualized medication management plan for the client [resident]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		

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02310	Continued From page 34	02310		
02310 SS=D	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide care and services according to acceptable health care standards, medical or nursing standards for one of one resident (R1) who utilized bed rails with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings included: R1 admitted for services on January 20, 2019, under the comprehensive home care license and began receiving assisted living services on August 1, 2021. R1's diagnosis included paranoid schizophrenia (mental disorder characterized by delusions, hallucinations, disorganized thoughts, speech and behavior), traumatic brain injury, dementia, suicide attempt by substance overdose, attention	02310		

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02310	Continued From page 35 deficit hyperactivity disorder, hypertension, polysubstance dependence, major neurocognitive disorder and antisocial personality disorder. R1's unsigned Service Plan -Wavier dated July 14, 2021, indicated R1 received assistance with appointments, ambulation, meals, toileting, dressing, grooming, behavior management, medication management, nonmedical transportation, shopping and therapeutic exercises. On August 22, 2022, at 10:17 a.m., the surveyor observed two half rails on R1's hospital bed. R1's assessment titled 14/90 Change of Condition Day Admission dated July 14, 2022, included a bed rail assessment. R1's record included a Risk Agreement- Bed Rails dated January 20, 2019. The Risk Agreement-Bed Rails document included reason for bed rails, risks of bed rails, and measurements of bed rails. The Risk Agreement-Bed Rails lacked a resident or responsible party signature. On August 22, 2022, at 10:32 a.m., registered nurse (RN)-A stated the licensee was unable to have R1 sign paperwork due to cognitive status and R1 had received a guardian in 2021. In addition, RN-A stated R1's guardian was aware of bedrails however, R1's record lacked documentation of a risk and benefit conversation. The licensee's undated Use of Side Rails in the Home policy indicated the RN would document the teaching provided regarding the risk of using siderails to the resident, family or caregivers.	02310		

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02310	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

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

Type: Full
Date: *08/23/22*
Time: 11:49:55
Report: 1021221238

Food and Beverage Establishment Inspection Report

Location:
Maple Grove House
10245 94th Avenue North
Maple Grove, MN55369
Hennepin County, 27

Establishment Info:
ID #: 0038455
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7635283891
ID #:

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

The following orders were issued during this inspection.

7-200 Toxic Supplies and Applications

7-204.11 ** Priority 1 **

MN Rule 4626.1620 Discontinue using chemical sanitizers, including chemical sanitizing solutions generated on site and other chemical antimicrobials on food-contact surfaces that do not meet the requirements specified in 40 CFR part 180, section 180.940, or part 180, subpart E, section 180.2020.

CHLORINE CONCENTRATION IN THE SANI SPRAY BOTTLE MEASURED ABOVE 200PPM. SANI SPRAY BOTTLE WAS CORRECTED DURING INSPECTION TO A CONCENTRATION OF 100PPM. CORRECTED ON-SITE.

Comply By: 08/23/22

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

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

ESTABLISHMENT DOES NOT HAVE A MEASURING DEVICE ON-SITE THAT INDICATES THE FINAL UTENSIL SURFACE TEMPERATURE IN HIGH TEMPERATURE DISH MACHINE. PROVIDE. THERMOLABELS WERE LEFT ON-SITE. SEE COMMENTS.

Comply By: 08/26/22

4-300 Equipment Numbers and Capacities

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

NO TEST KIT ON-SITE TO MEASURE THE CONCENTRATION OF CHLORINE. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 08/26/22

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

GREASE FILTERS ABOVE STOVE CONTAIN ACCUMULATION OF GREASE. BOTTOM PART OF MICROWAVE (WHERE GREASE FILTERS ARE PLACED) CONTAINS SPLASHING OF GREASE. CLEAN AND MAINTAIN CLEAN.

Comply By: 08/26/22

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

KITCHEN HANDWASHING SINK AND BOTH HANDWASHING SINKS IN THE BATHROOMS ARE MISSING A HANDWASHING SIGN OR POSTER THAT REMIND FOOD EMPLOYEES TO WASH HANDS BEFORE RETURNING TO WORK. PROVIDE AS DESCRIBED IN RULE ABOVE.

Comply By: 08/26/22

Surface and Equipment Sanitizers

Chlorine: > 200PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE
Violation Issued: Yes

Chlorine: = 100PPM at Degrees Fahrenheit
Location: SANI SPRAY BOTTLE *CORRECTED
Violation Issued: No

Final Utensil Surface Temp: = at 180 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: MILK - MAYTAG REFRIGERATOR
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: APPLE SAUCE - MAYTAG REFRIGERATOR
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH REGISTERED NURSE, JOSEPHINE BALL AND HEALTH REGULATION DIVISION NURSE EVALUATOR, ASHLEY CREWS.

ESTABLISHMENT IS A RESIDENTIAL HOME AND IT CURRENTLY HAS ONLY TWO CLIENTS IN THE HOME.

Food and Beverage Establishment Inspection Report

PER CONVERSATION WITH JOSEPHINE, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0710B :

THE THERMOLABELS WILL HELP THE ESTABLISHMENT VERIFY THAT THEIR DISH MACHINE IS PROVIDING A FINAL UTENSIL SURFACE TEMPERATURE OF 160F OR ABOVE. ESTABLISHMENT PROVIDED THERMOLABELS. CORRECTED.

THE KITCHEN HAS RESIDENTIAL EQUIPMENT, WOOD CABINETS, POPCORN CEILING, LAMINATE FLOORS AND UNABLE TO VERIFY IF THE BASE CABINETS WERE NOT HOLLOW. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

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 1021221238 of 08/23/22.

Certified Food Protection Manager: JOSEPHINE M. BALL

Certification Number: FM110616 Expires: 03/31/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
JOSEPHINE BALL
RN

Signed: _____
Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us