DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

August 25, 2022

Administrator
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN 55721

RE: Project Number(s) SL30666015

Dear Administrator:

On August 22, 2022, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the June 9, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jessica Chenze

Jessie Chenze, Interim Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: Jessica.Chenze@state.mn.us
Phone: 218-332-5175| Fax: 218-332-5196

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Electronically Delivered

July 22, 2022

Administrator
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN 55721

RE: Project Number(s) SL30666015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on June 9, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $3,000.00

The total amount you are assessed is $3,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

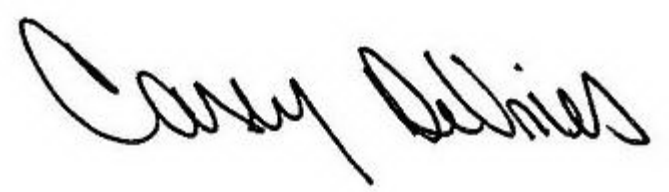
Free from Maltreatment reconsideration requests should be addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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: SL30666015-0 On June 6, 2022, through June 9, 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 sixteen (16) residents, all of whom received services under the provider's Assisted Living with Dementia Care license. On June 7, 2022, an immediate correction order related to an improperly functioning door system and a broken window was issued, tag identification 0800. On June 7, 2022, the immediacy of correction order 0800 related to improperly functioning locking door system and broken window was removed, however non-compliance remained at a scope and level of I.	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.	

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0 110	Continued From page 1	0 110		
0 110 SS=F	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record with the Board of Executives for Long Term Services and Supports (BELTSS). This had the potential to affect all the licensee's residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On June 6, 2022, at approximately 10:00 a.m., upon entrance, LALD-C indicated she was the LALD for the facility. LALD-C obtained an assisted living director license on April 27, 2022. On June 7, 2022, at 10:50 a.m., the BELTSS website indicated LALD-C held a current assisted living director license. The BELTSS website did	0 110		

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0 110	Continued From page 2 not identify LALD-C as the Director of Record for the licensee. On June 8, 2022, at approximately 3:00 p.m., LALD-C acknowledged she was not listed as the Director of Record for the licensee. LALD-C stated he was not aware of the requirement for the Director of Record. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records,	0 250		

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0 250	Continued From page 3 files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors.	0 250		

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0 250	Continued From page 4 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2022, at approximately 10:30 a.m., licensed assisted living director (LALD)-C stated the licensee's employees in charge of the facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent, (page four and five of the application), identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if	0 250		

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0 250	Continued From page 5 applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of	0 250		

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0 250	Continued From page 6 a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page five was electronically signed by the authorized agent/owner on May 26, 2021. The licensee had an assisted living license issued on August 1, 2021, with an expiration date of July 31, 2022. The licensee failed to ensure the following policies and procedures were developed and/or implemented: (1) conducting and handling background studies	0 250		

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0 250	Continued From page 7 on employees; (2) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (3) handling complaints regarding staff or services provided by staff; (4) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional; (5) orientation to and implementation of the assisted living bill of rights; (6) infection control practices; (7) medication and treatment management. On June 9, 2022, during the exit conference at approximately 2:20 p.m., LALD-C and registered nurse (RN)-D confirmed the licensee provided assisted living with dementia-care services but failed to implement corresponding policies and procedures, as required. As a result of this survey, the following orders were issued [0110, 0250, 0450, 0485, 0510, 0550, 0570, 0680, 0780, 0800, 0810, 0810, 0820, 0900, 0910, 0920, 0930, 0940, 1290, 1470, 1540, 1620, 1640, 1760, 1780, 1790, 1880, 1890, 2040, 2110, 2140, 2320, 2410 and 3090], indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 250		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 450	Continued From page 8	0 450		
0 450 SS=C	144G.41 Subdivision 1 Minimum requirements All assisted living facilities shall: (1) distribute to residents the assisted living bill of rights; (2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285; (3) utilize a person-centered planning and service delivery process; (4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure it provided the current Minnesota Bill of Rights for Assisted Living Bill to three of three residents (R1, R4, R5) with records reviewed. 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 the residents). The findings include: The licensee held a current Assisted Living with Dementia Care license.	0 450		

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0 450	Continued From page 9 Following the entrance conference on June 6, 2022, at approximately 12:31 p.m., licensed assisted living director (LALD)-C provided the surveyors the facility's admission packet. Included in the documents was the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, dated November 2019. LALD-C stated this was the version of the bill of rights the licensee provided to residents. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L administer insulin to R1. R1's record included acknowledgement dated December 12, 2021, of the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, dated November 2019. R4 On June 8, 2022, at approximately 8:50 a.m., the surveyor observed ULP-F administer R4's morning medications. R4's record included acknowledgement dated January 4, 2022, of receiving the Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers, dated November 2019. R5 On June 8, 2022, at approximately 7:30 a.m., the surveyor observed ULP-F administer R5's morning medications. R5's record included acknowledgement dated April 14, 2022, of receiving the Minnesota Home Care Bill of Rights for Assisted Living Clients of	0 450		

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0 450	Continued From page 10 Licensed Only Home Care Providers, dated November 2019. On June 9, 2022, at approximately 10:45 a.m., LALD-C confirmed R1, R4, R5, and all residents receiving services under the licensee's Assisted Living with Dementia Care License had not received the current Minnesota Bill of Rights for Assisted Living dated May 16, 2021. The licensee's Notice of Resident Rights policy, reviewed May 2, 2022, indicated the assisted living facility will notify residents of their rights before the initiation of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 450		
0 485 SS=C	144G.41 Subd 1. (13) (i) (A) and (C) 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: (A) menus must be prepared at least one week in advance, and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed	0 485		

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	30666	A. BUILDING: _____ B. WING _____	06/09/2022

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0 485	Continued From page 11 in advance of menu changes; (C) the facility cannot require a resident to include and pay for meals in their contract; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the daily food menu in all parts of the building. 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: On June 6, 2022, at approximately 11:00 a.m., during the tour of the facility, the surveyor observed weekly food menus were not post on memory care units B or C. On June 9, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-C acknowledged weekly food menus were only posted on unit A. LALD-C said menus were not posted or provided to the residents on memory care units B or C. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		

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0 510	Continued From page 12	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure infection control practices were followed related to glove use and hand hygiene for four of five unlicensed personnel ((ULP)-G, ULP-F, ULP-H, ULP-L) while providing personal cares. 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: INFECTION CONTROL/GLOVE USE On June 7, 2022, at approximately 6:35 a.m., the	0 510		

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0 510	Continued From page 13 surveyor observed ULP-H enter R10's room wearing gloves. ULP-H walked over to R10's bed, pulled back the covers to check if R10's adult brief required changing. ULP-H repositioned R10's covers and left R10's room without removing the gloves. ULP-H then entered R4's room (wearing the same gloves), walked over to R4's bed and pulled back the covers to check if R4's brief required changing. ULP-H repositioned R4's covers and left R4's room wearing the same gloves. ULP-H was questioned by the surveyor as to whether the ULP had changed gloves and washed hands between providing cares to R10 and R4. ULP-H stated she had not changed her gloves in between providing cares to R10 and R4. ULP-H added she should have changed her gloves and washed her hands in between residents. On June 7, 2022, at approximately 8:15 a.m., the surveyor observed ULP-F entered R4's room to provide morning cares. ULP-G also entered the room to assist ULP-F. Both ULP-F and ULP-G wore gloves on their hands. ULP-F and ULP-G removed R4's wet incontinent brief, ULP-F provided peri care, and applied a new brief. With the same gloved hands, ULP-F and ULP-G assisted R4 to put on clean pants. ULP-F and ULP-G both stated they did not change their gloves after changing R4's soiled brief and providing incontinence and peri care. ULP-F and ULP-H acknowledged they had been trained to change gloves after providing peri care. On June 9, 2022, at approximately 10:42 a.m. licensed assisted living director (LALD)-C and registered nurse (RN)-D both stated ULP-H, ULP-F and ULP-G did not follow the licensee's policy pertaining to changing of gloves and hand hygiene. RN-D stated the ULP are to change	0 510		

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0 510	Continued From page 14 gloves and wash hands in between residents and after providing peri care to residents. HAND HYGIENE DURING MEDICATION PASS On June 7, 2022, at approximately 7:15 a.m., the surveyor observed ULP-L begin the morning medication pass. In the medication (med) room, ULP-L prepared pills and gathered supplies to test R1's blood sugar. After entering R1's room, ULP-L repositioned R1 in her bed, donned a pair of gloves, then obtained a blood sugar from R1. ULP-L removed gloves, exited R1's room and returned to the medication room. ULP-L performed no hand hygiene. ULP-L documented R1's blood sugar on the computer, checked the temperature of the medication refrigerator and entered information into the computer. ULP-L then prepared R1's oral medications, gathered two insulins pens and supplies for R1, prepped the pens, donned a pair of gloves and returned to R1's room. At about 7:40 a.m., ULP-L administered R1's insulins and other medications. Before leaving the room ULP-L removed the gloves and returned to the med room. ULP-L did not perform any kind of hand hygiene. At about 7:45 a.m., ULP-L gathered supplies and equipment to test R10's blood sugar, who was seated alone at table in the dining area. After obtaining R10's blood sugar, ULP-L returned to the med room, disposed of the testing strips in her gloves while she removed them, then documented R10's blood sugar results in the computer. Again, ULP-L did not perform hand hygiene. At approximately 7:54 a.m., ULP-L returned to the medication room and set up pills for R7, then took the cup pills into the kitchen/dining area where R7 was seated at a table. ULP-L retrieved a jar of applesauce from the refrigerator and poured some into a small	0 510		

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0 510	Continued From page 15	0 510		

bowl, stating R7 liked the pills in applesauce. ULP-L delivered the bowl of pills and a spoon, to R7 at the table, then returned to the med room. ULP-L still had not performed any kind of hand hygiene. In the medication room, at approximately 8:00 a.m., before ULP-L went to prepare medications for the next resident, the surveyor asked ULP-L when hand hygiene was to be done and reported the lack of hand washing during the medication pass thus far.

At approximately 8:03 a.m. ULP-L said she really "didn't think" about washing hands while passing the medications to the residents. She then exited the medication room and washed hands with running hot water and soap in the dining area sink. At approximately 8:29 a.m., ULP-L stated she was "pretty busy" with medications and as far as hand washing "I honestly don't even think about it." ULP-L said she just got into the "groove" about what she was doing and "that is what I do." ULP-L said they've had courses on infection control, specifically with handwashing and added she should wash or at least sanitize hands with hand rub between residents.

Review of ULP-L's Medication Administration Routes Skill Competency, dated April 12, 2022, indicated hand washing was to be done before and after each resident's medication administration. ULP-L's record also included a competency for handwashing, dated April 12, 2022. The record indicated ULP-L successfully demonstrated both tasks.

On June 8, 2022, at approximately 4:19 p.m., registered nurse (RN)-D stated handwashing was expected before and after handling food, medications, using the bathroom and between residents. RN-D stated "of course" staff should

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0 510	Continued From page 16 wash hands before and after any resident contact, including after removing gloves. RN-D stated you can't have enough infection control education for staff, including basic hand hygiene. The Licensee's Hand Hygiene policy revised May 2, 2022, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and body fluids or a contaminated item, such as soiled linens. The policy directed that after removing and properly disposing of them, to re-wash hands. The licensee's Hand Hygiene policy, revised May 2, 2022, indicated handwashing, the single most effective way of controlling the spread of infection, will be performed by staff routinely and thoroughly to protect residents from the spread of infection. The policy indicated hands should be washed or decontaminated including before and after direct contact with resident and after removing gloves or gown. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 510		
0 550 SS=C	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and	0 550		

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0 550	Continued From page 17 the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required information related to its grievance procedure, contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all 16 residents, staff and visitors. 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: During a facility tour on June 6, 2022, at approximately 11:00 a.m., with licensed practical nurse (LPN)-K, the surveyor noted the main entrance and common areas lacked the required posting of the grievance procedure. Also there lacked posting or disclosure of contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and information for reporting suspected maltreatment to the MAARC.	0 550		

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0 550	Continued From page 18 On June 9, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-C confirmed the required information, as described above, was not posted in the facility public areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all of the licensee's current residents, staff and visitors. 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: On June 6, 2022, at approximately 10:00 a.m., upon entering the building, the facility's license was not displayed or posted at or near the main	0 570		

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0 570	Continued From page 19 entrance as required. The surveyor observed the license posted in the nursing office. On June 6, 2022, at approximately 11:42 a.m., licensed assisted living director (LALD)-C confirmed the facility's license was not posted at the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570		
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 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	0 680		

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0 680	Continued From page 20 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 (EP) with all required content and failed to post the plan prominently. In addition, the licensee failed to ensure its missing person policy contained all required content and was updated at least quarterly. This had the potential to affect all 16 residents, staff and any visitors of the facility. 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: Upon entrance to the facility on June 6, 2022, at approximately 10:17 a.m., the surveyor observed there was no signage posted or information regarding the licensee's emergency preparedness plan. Except for posting of emergency exits, nothing regarding an emergency preparedness plan was posted or displayed in the facility's main entrance or in the area near the nursing room. The surveyor also observed a second entry way, on the assisted living "C" unit, also lacked any signage or information regarding the licensee's EP plan.	0 680		

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0 680	Continued From page 21 During the entrance conference on June 6, 2022, at approximately 12:30 p.m., a request was made to licensed assisted living director (LALD)-C to view the licensee's emergency preparedness plan, including the missing resident policy/procedures. MISSING RESIDENT PLAN Contained in the licensee's EP plan was the licensee's missing resident policy. The missing resident policy did not: -identify a staff member for each shift who is responsible for implementing the missing resident plan and ensure at least one staff member who is responsible for implementing the plan is on site 24 hours a day, seven days a week; -require that the staff alert the staff identified above immediately if it is suspected that a resident may be missing; and -identify staff by position description who are responsible for searching for missing or suspected missing residents. There was no evidence the plan had been reviewed by the assisted living director and clinical director at least quarterly. EMERGENCY PREPAREDNESS PLAN The licensee's EP plan was undated and was a collection of a Risk Analysis tool and polices addressing: fire, fire drills and equipment, bomb threat, heat/humidify, electrical outage and HVAC failure, severe winter weather, chemical exposure, sheltering in place, evacuation and others. The hazard vulnerability assessment was dated April 15, 2022, but was unclear what the licensee specifically identified as vulnerabilities to its site. Except for the Risk Analysis, the plan and documents were undated and were not tailored to	0 680		

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0 680	Continued From page 22 the facility's site. The licensee's EP plan lacked the following required content: -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff; -development of all policies/procedures, based on assessment; and additional policies for: -sheltering in place: subsistence needs for staff and patients; -procedures for tracing of staff and patients; -handling medical documents; -handling and use of volunteers; -arrangements with other facilities; and -policies/procedures to address role of facility under a waiver declared by Secretary. -development of a communication plan: -including primary and alternate means for communication; (the plan lacked phone lists for staff, resident physicians, state and local emergency personnel and agencies and other requirements from appendix Z); -methods for sharing information; -sharing information on occupancy/needs; -method for sharing info/notifications with family; -EP training and testing program; -training program for staff; and -annual EP testing requirements. On June 9, 2022, at approximately 12:22 p.m., LALD-C stated their emergency preparedness plan was purchased and created with help of a consultant. After reviewing the plan with the surveyors, LALD-C acknowledged shortcomings	0 680		

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0 680	Continued From page 23 with the current plan and documentation of training related to the plan. LALD-C said the resident assessment was included in their electronic records system and the location of that information was in the plan. LALD-C verified the plan was not dated, lacked numerous polices, was missing components of a communication plan and lacked any documentation of training and testing. LALD-C stated they will work to revise, update and improve the plan to ensure it meets the new state requirements of emergency preparedness. No additional 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 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	0 780		

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MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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
0 780	Continued From page 24 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 ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 June 7, 2022, between 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed that when the smoke alarm was tested in resident room 7C, none of the other smoke alarms were activated. All other smoke alarms that were tested within building C were interconnected. During the tour interview, RN-D confirmed that this smoke alarm was not interconnected. No further information was provided.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	06/09/2022

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0 780	Continued From page 25 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=I	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, interview and record review, the licensee failed to ensure a locking door system consistently functioned properly to prevent egress for one of one resident (R5) with record reviewed. In addition, the licensee failed to ensure a broken window on the memory care unit was replaced or repaired in a manner to prohibit egress when the licensee covered a broken window with cardboard. This had potential to affect all assisted living with dementia care residents who required a secured unit. 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 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).	0 800	On June 7, 2022, the immediacy of correction order 0800 related to improperly functioning locking door system and broken window was removed, however non-compliance remained at a scope and level of I.	

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0 800	Continued From page 26 The findings include: IMPROPERLY FUNCTIONING LOCKING DOOR SYSTEM On June 6, 2022, at approximately 10:20 a.m., the surveyor observed a sign above the doorbell, next to the main entrance that stated, "We have a secure building. Push button for assistance". On June 6, 2022, at approximately 10:20 a.m., the licensee provided the surveyors with a resident roster, which indicated eight (8) residents required memory care services. On June 6, 2022, at approximately 10:30 a.m., following the entrance conference, the surveyor received a copy of the Uniform Disclosure of Assisted Living Services and Amenities (UDALSA). The UDALSA indicated the information was current as of January 1, 2022. The UDALSA indicated the facility had a secured unit or building for wander or exit-seeking behaviors. R5 diagnoses included hypertension, major depressive disorder and dementia. R5's Individual Abuse Prevention Plan completed on May 17, 2022, indicated R5 was at risk for elopement/wandering. R5 had a history of elopement from a previous living facility. R5 will exit door if open and the opportunity is there. R5 is in a secure building. On June 7, 2022, at approximately 10:30 a.m., a Minnesota Department of Health Engineering surveyor toured the facility with registered nurse (RN)-D and observed the door at the end of the hallway on unit C (memory care unit) was not	0 800		

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0 800	Continued From page 27 secured. RN-D confirmed the door was not secured. On June 7, 2022, at approximately 1:30 p.m., the Minnesota Department of Health Engineer surveyor again tested the door at the end of the hallway on unit C. The door was not secured. On June 7, 2022, at approximately 1:37 p.m., the surveyor tested the operation of the facility's exit door at the west end of the building, memory care unit C. The door was a security door that had a magnet to keep the door shut unless a code was entered into a keypad on the wall to release the door. Initially, when the surveyor attempted trying to open the door, the magnet was engaged, and the door would not open. After entering the code, the magnet released, and the surveyor was able to pull the door open. There was an audible buzzing sound that continued when the door was put back in place, the surveyor was able to immediately re-open the door without having to put in any code. Near the upper right corner of the door was a small, rectangular-shaped plastic component that was attached to a wire which led to a magnet. It appeared the small component was intended to match up with a similar component located on the upper right corner of the door jamb trim. The component attached to the door jamb trim was loosely hanging and was not properly positioned to line up with the door, therefore, caused a malfunction in the security of the door. When the surveyor placed the component with the wire side by side next to the part on the door, the humming ceased, and the surveyor was unable to open the door. On June 7, 2022, at approximately 4:28 p.m., a surveyor reviewed the facilities web site. The web site indicated the facility offers two locked	0 800		

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0 800	Continued From page 28 memory care units. BROKEN WINDOW On June 6, 2022, at approximately 11:00 a.m., the surveyor observed during the facility tour with licensed practical nurse (LPN)-K, a broken window in the living room of unit C. The broken window was covered with cardboard that was secured only with gray and blue tape. LPN-K stated R5 broke the window and new window was on order. The open area of the broken window measured 19 1/2" (inches) wide, 53" in height. The window was 24" from the floor. R5's Incident Report dated April 25, 2022, at 4:30 p.m., indicated R5 punched staff multiple times in the back and arm. R5 took a chair from a charting station and broke the window on unit C. On June 7, 2022, between approximately 7:34 a.m., and 10:30 a.m., the surveyor observed R5 ambulate up and down the corridors mainly on the C unit. The licensee's Wandering and Egress Prevention in ALDC (Assisted Living Dementia Care) policy dated as lasted reviewed May 10, 2022, indicated the security features would be checked daily (alarms functioning, and are doors latching). No additional information was provided. TIME PERIOD FOR CORRECTION: Immediate On June 7, 2022, the immediacy of correction order 0800 related to improperly functioning locking door system and broken window was removed, however non-compliance remained at a scope and level of I.	0 800		

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0 800	Continued From page 29 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. 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: On June 7, 2022, between 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed the following: 1. Within the fenced outdoor activity space for residents, one septic tank cover was cracked. 2. Windows were not provided with screens in resident room 4 in building B and resident room 2 in building A. 3. The window screens were torn in resident room 3 in building B and in resident room 6 in building A. 4. Electrical panels were obstructed in the mechanical rooms for buildings A, B, and C. 5. In the shower room of building C, the floor of the shower stall was stained and gaps were noted between the junction of the shower wall and floor, which makes cleaning difficult. Additionally, the cover for the exhaust vent was dusty. The RN-D confirmed during the tour interview that the facility elements required maintenance and	0 800		

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0 800	Continued From page 30 that the mechanical rooms were used for storage which prevents access to the electrical panels. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	0 810		

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0 810	Continued From page 31 evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to provide the required plans, training, and drills for fire safety and evacuation. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On June 7, 2022, between 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed the following: 1. The evacuation map posted in building B did not identify the location and number of resident sleeping rooms. 2. No evacuation maps were posted in the A and C buildings. 3. A padlock was used to secure the fence gate for the outdoor activity space for residents in buildings B and C. The RN-D explained during the tour that they were unsure which employees had keys to this lock. This secure outdoor space was accessed through two marked exit doors. In an interview with the licensed assisted living	0 810		

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0 810	Continued From page 32 director (LALD)-C, at approximately 2:25 p.m., they confirmed that evacuation maps were not posted in buildings A and C. The LALD-C also confirmed that the evacuation map posted in building B did not identify the location and number of resident sleeping rooms. On June 7, 2022, at approximately 12:15 p.m., the LALD-C provided documents for review. Documents were reviewed by survey staff on June 7, 2022, between 12:15 p.m. and 12:45 p.m. The fire safety and evacuation plans were not developed and maintained for the facility location. 1. The Fire Safety and Equipment Policy references a facility map, but a map was not included. 2. The Fire Response Policy references exits and pull fire alarms, but locations are not identified. 3. The location and number of resident sleeping rooms were not identified in the plans or policies provided. 4. The policies and plans provided did not address the locked fence gate. 5. The policies and plans failed to identify unique or unusual resident needs for movement or evacuation. 6. Employee training records for fire safety and evacuation were requested but not provided. The LALD-C explained during an interview at approximately 2:25 p.m. that employees are trained upon hire and every 6 months. 7. Documentation for resident training on fire safety and evacuation was requested but not provided. The LALD-C explained during an interview at approximately 2:25 p.m. that resident training had not yet been completed. 8. The Fire Drill Policy stated that evacuation drills are to be completed twice per year per shift. Evacuation drill logs dated 01-06-22 and 02-13-22 were provided. The licensee failed to	0 810		

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0 810	Continued From page 33 provide an evacuation drill frequency of at least one evacuation drill every other month. On June 7, 2022, at approximately 2:25 p.m., the LALD-C confirmed during an interview that the licensee failed to provide the required content within the fire safety and evacuation plans. They also confirmed that the training and drill frequency were not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure all physical facility elements, including the exit doors, do not create a distinct hazard to residents and staff. This affected all residents, staff, and visitors.	0 820		

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0 820	Continued From page 34 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: On June 7, 2022, between 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed the following: 1. Deadbolt locks had been installed on some of the exit doors that were provided with keypads. 2. The thumb turn had been removed from two of the deadbolt locks on exit doors, one in building A and the other in building C. 3. When the code was entered by RN-D into the keypad for the exit door that led to the patio from building C, the door did not open. The RN-D explained that she thought something was broken which was preventing the door from opening. 4. When the code was entered by RN-D into the keypad for the exit door that led to the patio from building B, the door did not open initially. With assistance from other employees and after several attempts, the exit door opened after a code was entered into the keypad. 5. When the code was entered by RN-D into the keypad for the marked exit door at the end of the hallway in building A, the door would not open. In the event of evacuation, exit doors with keypads that do not function properly and use of deadbolt locks would prevent a safe and quick exit. During the tour interview, the RN-D explained that	0 820		

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0 820	Continued From page 35 only some residents in building A knew the codes for the exit door keypads. The RN-D confirmed that the codes for the keypads were not working at some of the exit doors. The RN-D explained that the exit doors could be opened where deadbolt locks had been installed; including the locks where the thumb turns had been removed. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
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: (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	0 900		

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0 900	Continued From page 36 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 observation, interview and record review, the licensee failed to execute an assisted living contract to include all required content for one resident (R5) receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5's service plan dated April 14, 2022, indicated R5 received the following services: daily medication administration, bathing and grooming assistance, housekeeping and laundry. On June 7, 2022, at approximately 7:30 a.m., the surveyor observed unlicensed personnel (ULP) F administer R5's morning medications. R5's records lacked a written contract with the following required content:	0 900		

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0 900	Continued From page 37 (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. On June 9, 2022, at approximately 10:34 a.m., licensed assisted living director (LALD)-C and registered nurse (RN)-D both acknowledged R5's record lacked evidence the licensee established an assisted living contract for R5. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910		

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	30666	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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
0 910	Continued From page 38 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written, assisted living contact with all required content for two of two residents (R1, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R4's assisted living contract lacked the license number of the facility. R1 R1's Service Plan, revised May 25, 2022, indicated services included: medication administration, dependence for activities of daily living (ADL's), assistance with grooming, nail care, escort and mobility, housekeeping and laundry. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L administer medication to R1. R1's Resident Agreement Assisted Living with Dementia Care contract, signed by R1's legal representative and dated January 25, 2022, lacked content described above. R4	0 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 910	Continued From page 39 R4's service plan, dated January 1, 2022, indicated services included, medication administration, assistance with bathing, grooming, transfers, toileting, laundry and housekeeping. On June 7, 2022, at approximately 8:50 a.m., the surveyor observed ULP-F administer R4's morning medications. R4's Resident Agreement Assisted Living with Dementia Care contract, signed by R4's legal representative and dated January 4, 2022, lacked content described above. On June 9, 2022, at approximately 12:11 p.m., licensed assisted living director (LALD)-C stated she realized items were missing from the contracts. LALD-C said they would wait to get the State report to see what specifically was missing, then would make the changes and get new contracts out, make changes or add addendums. LALD-C said this would be the case for all residents' contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		
0 920 SS=C	144G.50 Subd. 2 (c) Contract information (c) The contract must include: (1) a disclosure of the category of assisted living facility license held by the facility and, if the facility is not an assisted living facility with dementia	0 920		

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0 920	Continued From page 40 care, a disclosure that it does not hold an assisted living facility with dementia care license; (2) a description of all the terms and conditions of the contract, including a description of and any limitations to the housing or assisted living services to be provided for the contracted amount; (3) a delineation of the cost and nature of any other services to be provided for an additional fee; (4) a delineation and description of any additional fees the resident may be required to pay if the resident's condition changes during the term of the contract; (5) a delineation of the grounds under which the resident may be discharged, evicted, or transferred or have services terminated; (6) billing and payment procedures and requirements; and (7) disclosure of the facility's ability to provide specialized diets. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written, assisted living contact with all required content for two of two residents (R1, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 920		

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0 920	Continued From page 41 R1 and R4's assisted living contract lacked disclosure of category of Assisted Living Facility license held and disclosure if not licensed as an assisted living facility with dementia care. R1 R1's service plan, revised May 25, 2022, indicated services included: medication administration, dependence for activities of daily living (ADL's), assistance with grooming and nail care, escort/mobility assistance, housekeeping and laundry services. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L administer medication to R1. R1's Resident Agreement Assisted Living with Dementia Care contract, signed by R1's legal representative and dated January 25, 2022, lacked content described above. R4 R4's service plan, dated January 1, 2022, indicated services included, medication administration, assistance with bathing, grooming, transfers, toileting, laundry and housekeeping. On June 7, 2022, at approximately 8:50 a.m., the surveyor observed ULP-F administer R4's morning medications. R4's Resident Agreement Assisted Living with Dementia Care contract, signed by R4's legal representative and dated January 4, 2022, lacked content described above. On June 9, 2022, at approximately 12:11 p.m.,	0 920		

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0 920	Continued From page 42 licensed assisted living director (LALD)-C stated she realized items were missing from the contracts. LALD-C said they would wait to get the State report to see what specifically was missing, then would make the changes and get new contracts out, make changes or add addendums. LALD-C said this would be the case for all residents' contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 920		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints;	0 930		

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0 930	Continued From page 43 (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written, assisted living contact with all required content for two of two residents (R1, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R4's assisted living contract lacked description of the Assisted Living Facility's complaint resolution process, including name and contact information of person who is designated to handle/resolve complaints. R1 R1's service plan, revised May 25, 2022, indicated services included: medication administration, dependence for activities of daily living (ADLs), assistance with grooming and nail care, escort/mobility assistance, housekeeping and laundry services. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L administer medication to R1.	0 930		

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0 930	Continued From page 44 R1's Resident Agreement Assisted Living with Dementia Care contract, signed by R1's legal representative and dated January 25, 2022, lacked the content described above. R4 R4's service plan, dated January 1, 2022, indicated services included, medication administration, assistance with bathing, grooming, transfers, toileting, laundry and housekeeping. On June 7, 2022, at approximately 8:50 a.m., the surveyor observed ULP-F administer R4's morning medications. R4's Resident Agreement Assisted Living with Dementia Care contract, signed by R4's legal representative and dated January 4, 2022, lacked the content described above. On June 9, 2022, at approximately 12:11 p.m., licensed assisted living director (LALD)-C stated she realized items were missing from the contracts. LALD-C said they would wait to get the State report to see what specifically was missing, then would make the changes and get new contracts out, make changes or add addendums. LALD-C said this would be the case for all residents' contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		

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0 940	Continued From page 45	0 940		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center.	0 940		

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0 940	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written, assisted living contact with all required content for two of two residents (R1, R4) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 and R4's assisted living contract lacked a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including whether the facility requires residents to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required. R1 R1's service plan, revised May 25, 2022, indicated services included: medication administration, dependence for activities of daily living (ADL's), assistance with grooming and nail care, escort/mobility assistance, housekeeping and laundry services. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L	0 940		

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0 940	Continued From page 47 administer medication to R1. R1's Resident Agreement Assisted Living with Dementia Care contract, signed by R1's legal representative and dated January 25, 2022, lacked the content described above. R4 R4's service plan, dated January 1, 2022, indicated services included, medication administration, assistance with bathing, grooming, transfers, toileting, laundry and housekeeping. On June 7, 2022, at approximately 8:50 a.m., the surveyor observed ULP-F administer R4's morning medications. R4's Resident Agreement Assisted Living with Dementia Care contract, signed by R4's legal representative and dated January 4, 2022, lacked the content described above. On June 9, 2022, at approximately 12:11 p.m., licensed assisted living director (LALD)-C stated she realized items were missing from the contracts. LALD-C said they would wait to get the State report to see what specifically was missing, then would make the changes and get new contracts out, make changes or add addendums. LALD-C said this would be the case for all residents' contracts. A policy regarding resident assisted living contracts was not available. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		

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01290 SS=E	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 interview and record review, the licensee failed to ensure current employee records contained all the required content to include background studies for three of four employees (unlicensed personnel (ULP)-H, ULP-L, and registered nurse (RN)-D) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	01290		

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01290	Continued From page 49 The finding include: ULP-H ULP-H started employment on June 18, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-H's employee record contained a background study dated June 18, 2018, that was affiliated under the licensee's former comprehensive license. ULP-L ULP-L started employment on June 18, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-L's employee record contained a background study dated June 8, 2021, that was affiliated under the licensee's former comprehensive license. RN-D RN-D started employment July 19, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021. RN-D's employee record contained a background study dated June 8, 2021, that was affiliated under the licensee's former comprehensive license. On June 9, 2022, at approximately 10:45 a.m., licensed assisted living director (LALD)-C confirmed the verification of Net Study indicated ULP-H's background study was not affiliated with the licensee's current assisted living with	01290		

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01290	Continued From page 50 dementia care licensee. The licensee's Screening of Job Applicants policy, last reviewed, May 2, 2022, indicated all job applicants will have a background check. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 51 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure orientation to assisted living was completed for one of four unlicensed personnel (ULP)-L with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01470	Continued From page 52 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: ULP-L was hired June 18, 2021, to provide direct care and services to the licensee's residents. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L administer medications to R1. ULP-L's training record lacked evidence of orientation to assisting living facility licensing requirements to include: -an overview of 144G statutes; -introduction and review of the provider's policies and procedures related to the provision of assisted living services under 144G statutes; -handling of emergencies and use of emergency services; -compliance with reporting and the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and	01470		

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	30666	A. BUILDING: _____ B. WING _____	06/09/2022

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01470	Continued From page 53 Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services and; -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On June 9, 2022, at approximately 12:14 p.m., licensed assisted living director (LALD)-C stated, regarding the orientation to assisted living, some (employees) had done it, and some had not. LALD-C said it had been an issue trying to get staff to complete training when the licensee ran short of staff. LALD-C said she needed to schedule time for the staff to complete the training. LALD-C verified ULP-C's record lacked evidence of having completed orientation. The licensee's Assisted Living & Assisted Living with Memory Care Orientation - All Staff policy, revised May 2, 2022, indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. The policy included the topics of orientation as detailed above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01470		
01540 SS=E	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics	01540		

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01540	Continued From page 54 specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure two of three direct-care employees (unlicensed personnel (ULP)-F and ULP-H) completed at least eight hours of initial dementia-care training with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: ULP-F ULP-F was hired on March 22, 2022, to provide direct care under the assisted living with	01540		

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01540	Continued From page 55 dementia care license. On June 7, 2022, at approximately 7:30 a.m., the surveyor observed ULP-F administer R5's morning medications. ULP-F's employee record indicated ULP-F had completed 7.5 hours of dementia training. ULP-H ULP-H started employment on June 18, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On June 7, 2022, at approximately 6:35 a.m., the surveyor observed ULP-H provide direct care to R10. ULP-H's employee record lacked evidence to indicate the ULP had completed any hours of dementia training. On June 9, 2022, at approximately 10:35 a.m., licensed assisted living director (LALD)-C confirmed ULP-F had only received 7.5 hours of dementia training and ULP-H's employee record lacked evidence ULP-H had received any of the 8 hours of dementia training. LALD-C stated both ULP-F and ULP-H had worked more than 80 hours. The licensee's Assisted Living with Memory Care Dementia Training policy reviewed May 2, 2022, indicated, direct care employees will complete a minimum of 8 hours initial training on dementia care topics. Initial training will be completed within 80 hours of employment start date. No further information was provided.	01540		

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01540	Continued From page 56 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must 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 observation, interview and record review, the licensee failed to ensure resident monitoring and reviews were conducted as needed with changes in condition for one of three residents (R4) with records reviewed.	01620		

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01620	Continued From page 57 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: R4's record lacked evidence an accurate reassessment was completed after a change of condition. R4's diagnoses included dementia, essential hypertension, spinal stenosis and late onset Alzheimer's disease. R4's Service Plan dated January 4, 2022, indicated R4 received the following services: assistance with bathing, dressing grooming, transfer assistance three (3) times a day, toileting assistance three (3) times a day, medication administration, laundry, housekeeping and safety checks three (3) times a day. R4's Assessment dated May 16, 2022, indicated R4 required assistance of one staff to sit up in bed, needed help to turn side to side, needed the help of one person and gait belt during transfers; and staff were to check and change R4 every three hours and as needed, and perform hourly safety checks. R4's assessment did not address R4's limited range of motion. On June 7, 2022, at approximately 8:18 a.m., the surveyor observed unlicensed personnel (ULP)-F	01620		

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01620	Continued From page 58 and ULP-G provide cares to R4. R4 was lying in bed with her knees drawn up tightly to her chest. R4 did not cooperate or participate in dressing which required ULP-F and ULP-G to straighten out R4's legs in order to get the resident's pants on. ULP-F and ULP-G placed a lift sling under R4 and used a mechanical, full-body lift to transfer R4 from the bed to the chair. ULP-F stated she was not sure how long they have been using the mechanical lift to transfer R4. On June 7, 2022, at approximately 9:00 a.m., R4's hospice registered nurse (RN) stated R4 was a two-person transfer with the use of a mechanical lift. The hospice RN stated that hospice staff were doing stretching exercises with R4. On June 9, 2022, at approximately 10:35 a.m., RN-D stated she was not aware staff were having to use the mechanical lift to transfer R4 from bed to the chair. RN-D acknowledged she had not reassessed R4's changes in mobility and transfer ability. The licensee's Initial and On Going Nursing Assessment of Resident policy, reviewed May 2, 2022, indicated the RN will reassess the resident if the resident's condition changes. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01640 SS=E	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640		

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01640	Continued From page 59 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure all services identified in the service plan were implemented for one of one resident (R1) with records reviewed. In addition, the licensee failed to update the service plan to reflect the services provided for one of four residents (R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a	01640		

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01640	Continued From page 60	01640		

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:

SERVICE PLAN NOT IMPLEMENTED

R1's diagnoses included liver failure, hypertension, diabetes mellitus, knee pain, stage 3 chronic kidney disease, arthritis, neuropathy, urinary incontinence and constipation.

R1's comprehensive assessment, completed by registered nurse (RN)-M dated May 25, 2022, indicated R1 needed full assistance with activities of daily living including toileting, dressing, grooming, bathing and mobility. The assessment indicated R1 was to be toileted every 3 hours as needed during awake hours and at 3:00 a.m., during the night. Further, staff would perform peri-care on R1 with each continent and incontinent void.

R1's service plan, revised May 25, 2022, indicated the resident's services included toileting. R1's Master Care Plan - with Services, dated Mary 25, 2022, identified R1's toileting needs and directed staff to check and change R1 every three hours and as needed during awake hours and at 0300 hours (3:00 a.m.) on the night shift per resident and family request.

On June 7, 2022, at approximately 5:18 a.m., unlicensed personnel (ULP)-J stated she needed to complete rounds and safety checks on all residents on the unit, including R1. ULP-J stated R1 was checked at the beginning of the night shift, around 11:00 p.m., then again at 3:00 a.m.

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01640	Continued From page 61 ULP-J stated usually R1 was frequently "incontinent " of urine and had to be changed at least once during mid shift. The surveyor observed ULP-J knock, then enter R1's room, don a glove and check R1's brief for wetness. ULP-J indicated R1 did not need to be changed and repositioned R1. On June 7, 2022, from approximately 5:18 a.m., until 9:00 a.m., for about 3 hours and 45 minutes, the surveyor made continuous observations of R1. At approximately 7:15 a.m., ULP-L entered R1's room to check R1's blood sugar level and did a cursory check of R1's incontinent brief. When ULP-L pulled back the blanket, R1's brief was exposed, and it was visibly wet and puffy. ULP-L completed the blood sugar check, repositioned R1 and left the room. ULP-L returned at approximately 7:40 a.m., to administer morning medications and insulin to R1; ULP-L did not check or perform incontinence care for R1. R1 remained in bed until approximately 9:00 a.m., when ULP-L and ULP-N arrived in the resident's room and announced they would get R1 up for the day. R1's room smelled of urine. The ULPs used a mechanical lift to transfer R1 from bed to the toilet in the bathroom. When R1 was lifted up, R1's blankets and linens were visibly soiled and wet from urine. Once in the bathroom, ULP-N removed R1's incontinent brief and placed it in the trash can; the brief was soaked full. In the presence of the surveyor, ULP-L and ULP-N provided incontinence care for R1. In the presence of the ULPs, the surveyor inspected R1's buttocks; there was no indication of redness, maceration or open areas. ULP-N applied barrier cream to R1's bottom, then completed dressing and grooming the resident. On June 7, 2022, at approximately 9:28 a.m.,	01640		

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01640	Continued From page 62 ULP-N stated R1's brief was "saturated" and the bed "was soaked." ULP-L said R1 should have been changed earlier, that "I should have" changed her when I went to check her blood sugar. ULP-L said she knew R1 was to be checked and changed at least every three hours. On June 8, 2022, at approximately 3:58 p.m., registered nurse (RN)-D stated R1 was to be changed if needed or checked at least every three hours during the day, and then once during the night. RN-D said R1 should have been changed right at the change of shift and was disappointed to learn this did not happen and R1's care plan was not followed. SERVICE PLAN NOT UPDATED R4's service plan was not updated to reflect the services the resident was currently receiving. R4's diagnoses included dementia, essential hypertension, spinal stenosis and late onset Alzheimer's disease. R4's service plan dated January 4, 2022, indicated R4 received the following services: assistance with bathing, dressing grooming, transfer assistance three (3) times a day, toileting assistance three (3) times a day, medication administration, laundry, housekeeping and safety checks three (3) times a day. R4's Assessment dated May 16, 2022, indicated R4 needed assistance of one staff to sit up in bed, help to turn side to side, help of one person and gait belt during transfers, staff check and change R4 every three hours and as needed and perform hourly safety checks. R4's Assessment did not address R4's limited range of motion.	01640		

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01640	Continued From page 63 On June 7, 2022, at approximately 5:05 a.m., ULP-H stated during the night shift she checked and changed R4 every three (3) hours and completed hourly safety checks. R4's service delivery record for May and June 2022 indicated R4 was checked and changed every three hours and hourly safety checks were completed. R4's services plan had not been updated to reflect the changes in toileting every three (3) hours and hourly safety checks. The licensee's Content of the Service Plan policy, reviewed May 2, 2022, indicated the facility will implement and provide all services required by the current service plan. Additionally, the policy indicated service plans are reviewed and revised as needed, based upon on-going resident assessments. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
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	01760		

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01760	Continued From page 64 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 administered as ordered for one of one resident (R1) observed during medication pass 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: R1's diagnoses included liver failure, hypertension, diabetes mellitus, knee pain, stage 3 chronic kidney disease, arthritis, neuropathy, urinary incontinence and constipation. R1's Service Plan, revised May 25, 2022, and medication management plan, revised May 25, 2022, indicated the resident received medication management services. The medication management plan indicated trained staff will administer injectable medications and the nurse will update staff of any special instructions as needed. R1's prescriber's orders included two insulins. R1's order for Lantus (a long-acting insulin) dated May 9, 2022, directed inject 13 units subcutaneously twice daily. R1's order for	01760		

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01760	Continued From page 65 Novolog (a short acting insulin) dated May 16, 2022, directed inject 10 units with meals. Give 5 units if only ate 25-75% of the meal. Give no insulin if less than 25% of meal consumed. Chart how many units given. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L retrieve two insulin pens from the medication cart, read the dispensing instructions from the medication administration record (MAR) and prime R1's insulin pens. ULP-L took the supplies and medications and entered R1's room, donned a pair of gloves and prepared the resident's upper left arm for the insulin administration. ULP-L injected 10 units of Novolog insulin, then injected the Lantus insulin (13 units). Later, at approximately 9:33 a.m., (or about 1 3/4 hours after R1 was given her morning insulins) ULP-L served R1 breakfast in the resident's room: a cup of orange juice and a slice of buttered toast with jam. With encouragement, R1 began to eat and take some bites from the toast. On June 7, 2022, at approximately 9:40 a.m., the surveyor asked about what time R1 was given breakfast, relative to when R1 had her insulin. ULP-L stated she should not have given R1 insulin when she did but needed to see R1 eat and also how much R1 ate. ULP-L stated this was "on me" and denied she did it because she was rushed, adding that she just "got into a groove" with the morning's medications. ULP-L also stated she had been trained on passing medications, including giving insulin. Review of ULP-L's medication administration training competency, dated April 12, 2022, indicated ULP-L successfully demonstrated competency to administer insulin. On June 8, 2022, at approximately 4:04 p.m., registered nurse (RN)-D stated that although R1 had changes with her insulins, the unlicensed	01760		

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01760	Continued From page 66 staff were "pretty knowledgeable" about checking resident's blood sugars before meals and were good at waiting to give insulin after eating. RN-D said she could not explain why ULP-L administered R1's insulin at 7:30 in the morning and also that the staff needed to wait until to see how much R1 ate in order to give the correct dose. RN-D said this would be considered a medication error. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy, revised May 2, 2022, indicated unlicensed staff may administer medications, including insulin injections, following the RN's written instructions for administering the medications to the resident. The policy also indicated medications need to be administered according the "6 rights" which included the "right time." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice;	01780		

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01780	Continued From page 67 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. This has the potential to affect all 16 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) 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 June 6, 2022, at approximately 11:42 a.m., licensed assisted living director (LALD)-C confirmed all 16 residents who resided at the facility received medication management services. On June 9, 2022, at approximately 10:45 a.m., LALD-C and registered nurse (RN)-D both stated the RN would prepare resident medications for planned time away from home. RN-D stated the licensee did not have a policy pertaining to planned time away from home. RN-D confirmed the licensee's Delegation of Medications to be Given to the Resident by Unlicensed Staff for Residents time away from home policy, last reviewed May 2, 2022, did not address the policies and procedures pertaining to planned time away from home.	01780		

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01780	Continued From page 68 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
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 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;	01790		

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01790	Continued From page 69 (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 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 written procedures for the unlicensed personnel (ULP) providing medications to residents having unplanned time away when the licensed nurse was not available. In addition, the licensee failed to ensure three of three unlicensed personnel ((ULP)-C, ULP-D, ULP-L) were trained and demonstrated competency to prepare and give medications for residents having unplanned time	01790		

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01790	Continued From page 70 away, with employee 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2022, at approximately 11:42 a.m., licensed assisted living director (LALD)-C confirmed all 16 residents who resided at the facility received medication management services. UNPLANNED TIMES AWAY POLICY AND PROCEDURE FOR ULP The licensee lacked a written procedure to include: - the type of container or containers to be used for the medication appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications where provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information;	01790		

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01790	Continued From page 71 - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP 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 medication returned. On June 9, 2022, at approximately 12:19 p.m., RN-D stated there would be residents who would need medications for unplanned times away and staff would send out medications with residents. RN-D acknowledged and stated they had no written procedures for unlicensed staff to follow to set up medications for unplanned times away. TRAINING AND COMPETENCY EVALUATIONS FOR UNPLANNED TIME AWAY ULP-F ULP-F was hired on March 22, 2022, to provide direct care under the assisted living with dementia care license. On June 7, 2022, at approximately 7:30 a.m., the surveyor observed ULP-F administer R5's morning medications. ULP-H ULP-H started employment on June 18, 2018, under the comprehensive home care license and began providing assisted living services on August 1, 2021, which included medication administration.	01790		

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01790	Continued From page 72 ULP-L ULP-L started employment on June 18, 2021, under the comprehensive home care license and began providing assisted living services on August 1, 2021, which included medication administration. On June 7, 2022, at approximately 7:19 a.m., the surveyor observed ULP-L administer medications to R1. ULP-F, ULP-H and ULP-L's employees' records lacked evidence to indicate they had been trained and had demonstrated competency to provide medications to residents for unplanned times away from home as the licensee's above noted procedure had not been fully developed. On June 9, 2022, at approximately 10:45 a.m., registered nurse (RN)-D confirmed ULP-F, ULP-H, and all unlicensed personnel providing services under the providers license had not been trained and had not demonstrated competency to prepare and give medications for residents having unplanned time away. Later at approximately 12:19 p.m., RN-D stated if there was no skills test on competencies for unplanned time away, staff had no training for this. The licensee's Delegation of Medication to be given to Residents by Unlicensed Staff for Residents time Away from home policy last reviewed May 2, 2022, indicated only unlicensed staff that were trained and had satisfactorily demonstrated competency would be able to prepare medications for unplanned time away from home. No further information was provided.	01790		

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01790	Continued From page 73 TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the licensee failed to ensure unused or expired medications utilized for training were securely stored. This had potential to affect all residents and facility staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: On June 6, 2022, at approximately 10:45 a.m., the surveyor observed on the counter in the activity room, two clear plastic bins that were not locked. One bin was labeled "Training Material" and contained the following: - one bottle of Gavilax (laxative); - eleven (11) packets of Ipratropium Bromide 0.5/Albuterol sulfate 3 mg (milligrams) ampoules	01880		

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01880	Continued From page 74 (used for nebulizer treatments) that expired June 2021; - one tube of Diclofenac sodium 1% gel (relieve pain); and - one bottle of Systane lubricant eye drops. The other bin was labeled "Training Bin" and contained the following: - four (4) epinephrine injections; and - one package of Ipratropium Bromide 0.5/Albuterol sulfate 3 mg ampoules that expired June 2021. On June 6, 2022, at approximately 12:45 p.m., licensed assisted living director (LALD)-C confirmed the two bins were unlocked and contained medications. LALD-C stated the medications in the two bins were used for training purposes and were usually kept in the main office. The licensee's Storage of Medications policy dated May 2, 2022, indicated medications would be handled and stored per acceptable standards. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890		

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01890	Continued From page 75 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were maintained bearing an original prescription label and dated when opened for time sensitive medications for two of two residents (R1, R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1 R1's Lantus Solostar (long-acting insulin) 100 units/mL (milliliter) lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy from which it had been issued. R1's Lantus insulin also lacked a date when the medication was first opened or when it expired. R1's Novolog (short-acting) insulin pen had area on its label where to write date opened and dated expired but had neither documented. Manufacturer's instructions for Lantus indicated the pen should be discarded after 42 days.	01890		

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01890	Continued From page 76 Manufacturer's instructions for Novolog indicated the pen should be discarded after 28 days. On June 7, 2022, at approximately 7:40 a.m., unlicensed personnel (ULP)-L verified the above findings for R1's insulin pens. R6 R6's diclofenac sodium 1% topical cream tube (for pain) and its packaging lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy from which it had been issued. The tube also lacked a date when the medication was first opened or when it expired. R6's three bottles of eye drop solution lacked dates the medications were first opened or when the expired. The eye drop medications included: -Ketorolac tromethamine 0.5% Ophthalmic solution (bottle had label upon which to write date opened/expired but had neither documented); -Prednosol Acetate 1% eye suspension (original package had area to write date opened/expired but had neither documented); and -Polyvinly Alcohol 1.4% lubricating drops; (original package had area to write date opened/expired but had neither documented). On June 7, 2022, at approximately 8:13 a.m., ULP-L showed the medications and packages to the surveyor and confirmed the lack of a label for the tube of Diclofenac gel and lack of date opened on dated for each of the eye medications. ULP-L stated the medications like eye drops and insulin were supposed to be dated when first opened for use. ULP-L also stated there usually was and should be, a label on the tube medication for pain or on the box, but did not	01890		

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01890	Continued From page 77 know why there was not and added she just looked at what was on the MAR (medication administration record) in the computer. ULP-L was unsure how long the insulin, pain medication or eye drops were good once opened. Manufacturer's instructions for Ketorolac tromethamine 0.5% Ophthalmic solutions indicated to discard after 28 days. Manufacturer's instructions for Prednosol Acetate 1% eye suspension indicated to discard after 28 days. On June 8, 2022, at approximately 10:45 a.m., registered nurse (RN)-D stated R1's insulin came from the VA (Veteran's Affairs) and only had the label on the box they came in. RN-D stated R6's pain gel was something new and probably over the counter but should have a pharmacy label. RN-D stated medications like insulin, eye drops, and other bottles should be dated when opened. RN-D said offhand they were not sure how long medications like eye drops lasted once opened but that usually they are good unopened until expiration date and once opened usually good for about four weeks or a month. RN-D stated staff are trained to date medications when opened. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01890		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that	02040		

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02040	Continued From page 78 has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, document review, and interview, the licensee failed to mitigate hazards identified on and around the property. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: On June 7, 2022, between 10:30 a.m. and 12:15 p.m., survey staff toured the facility with the registered nurse (RN)-D. During the facility tour, survey staff observed the following: 1. The laundry room in building B was unlocked and not staffed. 2. The laundry and mechanical rooms in building A were unlocked and not staffed. 3. Residents were able to move freely between	02040		

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02040	Continued From page 79 buildings A, B, and C. 4. A gas fireplace was located in building A. No barrier was installed to prevent residents from contacting the fireplace. 5. During the tour of building C, survey staff observed wall grates within resident rooms. Survey staff asked the RN-D to explain the function of these wall grates and they responded that they did not know. During the tour of building B, the grates were identified as covers for wall heaters. A wall heater was turned on and the surface was noted as hot in resident room 5 in building B. Additionally, some of the heaters had warning labels instructing the user to keep furnishings and combustibles at least 3 feet away from the front of the heater. Some heaters were not provided with these warning labels. These wall heaters were not identified as a hazard within the hazard vulnerability analysis. On June 7, 2022, at approximately 12:15 p.m., the LALD-C provided documents for review. Documents were reviewed by survey staff on June 7, 2022, between 12:15 p.m. and 12:45 p.m. A Hazard Vulnerability Analysis dated 01-11-22 was provided. Fireplaces and chemical storage areas were identified, but mitigation to protect residents from harm was not being followed for these identified hazards. The wall heaters installed within resident rooms had not been identified as a hazard within the analysis. On June 7, 2022, at approximately 2:25 p.m., the LALD-C confirmed during an interview that the licensee failed to identify and mitigate some of the hazards identified within the analysis. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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	30666	A. BUILDING: _____ B. WING _____	06/09/2022

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02040	Continued From page 80 (21) days	02040		
02110 SS=C	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of	02110		

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02110	Continued From page 81 move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure required dementia care policies and procedures were provided to each resident and/or the resident's legal and designated representative at the time of move-in. 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: The licensee lacked evidence the required policies and procedures related to dementia care were provided to each resident and/or the resident's legal and designated representative. The licensee held an assisted living with dementia care license and was licensed for a bed capacity of 30 residents. On June 9, 2022, at 10:42 a.m., the licensed assisted living director (LALD)-C confirmed the inclusive list of dementia care policies and procedures had not been provided to each resident and/or representative. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		

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02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the designated person overseeing staff training in the care of individuals with dementia, licensed assisted living director (LALD)-C, had documented evidence of competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 6, 2022, at approximately 11:41 a.m., LALD-C stated she was the person in charge of overseeing the dementia care training for staff. LALD-C stated	02140		

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02140	Continued From page 83 she completed "EduCare" (computer-based training) modules related to care of residents with dementia, and said she thought she had the needed proof she completed training. LALD-C's training transcript indicated the employee had completed the requisite number of required hours in dementia care. However, LALD-C's record lacked evidence LALD-C had demonstrated competency to be the person in charge of overseeing staff training. On June 9, 2022, at approximately 12:12 p.m., LALD-C stated she only had course transcripts as dementia training records which listed the courses completed. LALD-C said the competency tests for the courses were completed and graded in house. The licensee lacked a policy related to dementia training and the requirements of the trainer. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02140		
02320 SS=E	144G.91 Subd. 4 Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by:	02320		

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02320	Continued From page 84 Based on observation, interview and record review, the licensee failed to ensure medications were administered as ordered for 1 of 1 resident (R1) and that the unlicensed personnel directly observed medication administration for 1 of 4 residents (R7). In addition, the licensee failed to ensure medication procedures were followed during medication administration for 1 of 4 residents (R6). 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: MEDICATION NOT ADMINISTERED AS ORDERED R1's diagnoses included liver failure, hypertension, diabetes mellitus, knee pain, stage 3 chronic kidney disease, arthritis, neuropathy, urinary incontinence and constipation. R1's service plan dated December 7, 2021, and medication management plan dated May 25, 2022, both indicated R1 received services including administration of medications. R1's prescriber's orders included two insulins. R1's order for Novolog (a short-acting insulin) dated May 16, 2022, directed inject 10 units with meals. Give 5 units if only ate 25-75% of the	02320		

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02320	Continued From page 85 meal. Give no insulin if less than 25% of meal consumed. Chart how many units given. R1's order also included Lantus (a long-acting insulin) dated May 9, 2022, directed inject 13 units subcutaneously twice daily. On June 7, 2022, at approximately 7:40 a.m., the surveyor observed unlicensed personnel (ULP)-L prepare morning medications for R1 including insulin. ULP-L administered 10 units of R1's Novolog, even though R1 had not eaten. ULP-L then administered R1's Lantus insulin as ordered. The surveyor observed R1 received breakfast at approximately 9:33 a.m., or about one hour and forty-five minutes after getting the Novolog insulin. At approximately 9:40 a.m., ULP-L said she gave R1 her insulin around 7:30 a.m. ULP-L verified R1 was to have insulin after eating to see how much R1 ate to set the dose. ULP-L denied being rushed or hurried and said "I just got into a groove" with my morning medication. ULP-L stated she had been trained to pass medications, including insulin. On June 8, 2022, at approximately 4:04 p.m., registered nurse (RN)-D stated R1 had changes with her insulins but the unlicensed staff were "pretty knowledgeable" about checking resident's blood sugars before meals and were good at waiting to give insulin after eating. RN-D said she could not explain why ULP-L administered R1's insulin at 7:30 a.m., and also that the staff needed to wait until to see how much R1 ate in order to give the correct dose. RN-D said it would be considered a medication error. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel	02320		

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02320	Continued From page 86 policy, revised May 2, 2022, indicated unlicensed staff that satisfy the training requirements, have been determined competent to follow procedures and have been delegated responsibility by the RN may administer medications to the resident. The policy also indicated medications need to be administered according the "6 rights" which included the "right time." PROCEDURES NOT FOLLOWED DURING MEDICATION ADMINISTRATION R7 R7's diagnoses included hypertension, spinal stenosis, acute back pain, hyperlipidemia, gastroesophageal reflux disease, chronic kidney disease and type 2 diabetes. R7's prescriber's orders dated July 22, 2021, included medications for depression, anxiety, pain, esophageal reflux, elevated cholesterol, constipation, three blood pressure medications and dietary supplements. R7's Medication Management Plan revised June 8, 2022, indicated R7 received services including administration of medications. On June 7, 2022, at approximately 7:54 a.m., the surveyor observed ULP-L set up R7's morning pills in a small cup and bring them out to the dining area where R7 was seated. After pouring applesauce into a small bowl, ULP-L emptied R7's pills on top of the applesauce, then handed the bowl with pills and a spoon to R7, who began to scoop up and take medications. Even though R7 had just begun to take her medications, ULP-L immediately left the dining area and returned to the medication room where ULP-L	02320		

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02320	Continued From page 87 charted R7's medications had been administered. At approximately 9:49 a.m. the surveyor asked ULP-L about the medication administration for R7. ULP-L verified after giving R7 their pills with applesauce, she did not watch R7 actually take her medications and said [R7] was good about taking her pills and it was a practice ULP-L did. ULP-L then stated "no, it was not OK, I should have watched" [R7] take her pills and it was one of her habits. ULP-L said, "honestly I don't know what I started doing that." R6 R6's diagnoses included dementia, hypothyroidism, hyperlipidemia, osteoarthritis, hypertension, chronic pain syndrome and depression. R6's Service Plan dated December 8, 2021, and Medication Management Plan, revised June 7, 2022, both indicated R6 received services including administration of medication. R6's prescriber's orders dated July 22, 2021, included medications for depression, pain, mood stabilization, tremors, acid indigestion, thyroid, sleep, constipation, blood pressure medications and a dietary supplement. On June 7, 2022, at approximately 8:03 a.m., the surveyor observed ULP-L begin to set up R6's medications. ULP-L first brought up R6's mediation administration record (MAR) on the computer, which was positioned opposite the medication cart. ULP-L opened the cart and retrieved a stack of about ten blister packages for R6 and set them on top. ULP-L quickly glanced back at the computer screen over her shoulder, then ULP-L opened a locked compartment in a	02320		

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02320	Continued From page 88	02320		

drawer of the cart, where medications were stored. ULP-L retrieved a package from the locked drawer and without looking at the information on the computer, ULP-L punched out a pill from the bubble pack into a small cup and returned the bubble pack to the drawer and locked it. ULP-L then began to punch out R6's pills from the stack of bubble packs atop the cart. The surveyor observed ULP-L did not compare the labels on the bubble packs to the MAR on the computer. At about 8:07 a.m., ULP-L left the medication room with the pills and entered R6's room to administer her morning medications.

On June 7, 2022, at approximately 9:40 a.m., the surveyor asked ULP-L about her routine in setting up pills for R6, including comparing the medication labels to the MAR in the computer. ULP-L stated she's been here (working for the licensee) for over a year and "I know the pills" for R6 and the other residents by the shape and the number imprinted on the pills. ULP-L said I usually just "pop them out" (from the pharmacy prepared blister packaging) and also stated she did not compare and match up the medicine packages with the MAR. ULP-L said it was not something she was taught, rather it was, "just a bad habit." ULP-L said she should have compared each medication to what was in the MAR and stated, "I didn't do that, I'm guilty."

On June 8, 2022, at approximately 4:07 p.m., RN-D and licensed assisted living director (LALD)-C both expressed disappointment with observations of ULP-L's medication pass. RN-D said everybody was instructed to stay with the resident while they take their medications. RN-D stated medication set up should include comparing the medication label to the MAR and that staff were taught about the six rights; and

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02320	Continued From page 89 were expected to complete the checks. LALD-C and RN-D stated to remedy this, they planned to provide re-education and have all staff complete medication competencies. The licensee's Administration of Oral Medications policy, revised May 28, 2018, indicated the RN will train and competency test nursing staff including on the 6 rights of medication and how to administer medications. The policy directed that at time of administration, staff will follow the instructions for the client [resident], which included: read the label and compare to the MAR when preparing the medication for administration; and to watch and made sure the client swallows the pills and note any problems on the MAR. The licensee's Skill Competency Medication Administration - Routes document, undated, indicated in the procedures for administration of oral medications under #5 to observe the individual swallow pills. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	02320		
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service	02410		

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02410	Continued From page 90 plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure privacy was maintained during the provision of personal cares for two of two residents (R1, R4) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: R1	02410		

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02410	Continued From page 91 R1's diagnoses included liver failure, hypertension, diabetes mellitus, knee pain, stage 3 chronic kidney disease, arthritis, neuropathy, urinary incontinence and constipation. On June 7, 2022, at approximately 9:03 a.m., the surveyor observed unlicensed personnel (ULP)-L and ULP-N enter R1's room to provide toileting, dressing and grooming cares to get R1 ready for the day. After entering R1's room neither ULP-L nor ULP-N closed R1's room door. ULP-N positioned a full body lift next to R1's bed, placed a lift shift under R1 and with ULP-L, transferred R1 in the lift from the bed into the bathroom. At the same time another resident (R5), walked past the open doorway. R1 was transferred onto the toilet where ULP-L and ULP-N cleaned, dressed and groomed R1. During the next 10 minutes, R5 walked past R1's open door three additional times. Upon completion of morning cares, ULP-L and ULP-N transferred R1 into her Broda (specialized wheelchair with reclining features) chair. During the entire time ULP-L and ULP-N completed their tasks, R1 was not afforded privacy during the provision of cares. On June 7, 2022, at approximately 9:32 a.m., ULP-L acknowledged and stated they should have closed the door during R1's cares. ULP-L stated it was "very hot" and said it was done for our convenience and not the residents. ULP-L also said there were residents who liked to do walking laps and that was more reason why the door should be closed. "I think it is also related to dignity," ULP-L stated. R4 On June 7, 2022, at approximately 8:18 a.m., the surveyor observed ULP-F and ULP-G remove R4's adult brief, provide peri care, replace R4's adult brief and complete dressing R4. ULP-F and	02410		

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02410	Continued From page 92 ULP-G then transferred R4 into a chair using a mechanical lift. Neither ULP-F or ULP-G closed the blinds on the window that opened directly to the parking lot prior to providing care to R4. Both ULP-F and ULP-G stated they should have closed the blinds on the window prior to providing cares to R4. On June 9, 2022, at approximately 10:42 a.m., registered nurse (RN)-D and licensed assisted living director (LALD)-C both stated the ULP should have closed the binds on R4's window prior to providing care. RN-D stated residents often lose their private space, and they have to maintain dignity for the resident; it's one of their rights. No additional information was provided. Time period for correction: Twenty-one (21) days.	02410		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8.Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entryway of the establishment	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE WOODS ASSISTED LIVING	40170 COUNTY ROAD 257 COHASSET, MN 55721

(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
03090	Continued From page 93 to display statutory language to disclose electronic monitoring activity, potentially affecting all 16 residents, staff, and visitors of the licensee. 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 the potential to affect a large portion or all the residents). The findings include: On June 6, 2022, at approximately 10:15 a.m., the surveyor observed a sign posted inside the door of the main entrance. The sign read "Security Alert, 24 hour Videoed Surveillance, All activities are monitored and recorded". The sign lacked the required information. On June 6, 2022, at approximately 11:42 a.m., licensed assisted living director (LALD)-C confirmed there were video cameras throughout the facility that recorded video and sound. In addition, LALD-C confirmed the sign lacked the required information. The licensee's Electronic Monitoring: Sample Policy and Procedure with Communication Tools policy dated May 16, 2022, indicated [facility] shall post a sign at each facility entrance accessible to visitors that states "Electronic monitoring devices, including security cameras and audio devices may be present to record persons and activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30666	A. BUILDING: _____ B. WING _____	06/09/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
03090	Continued From page 94 (21) days	03090		

MINNESOTA DEPARTMENT OF HEALTH
Food, Pool,& lodging Services
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *06/06/22*
Time: 12:01:51
Report: 7939221113

Food and Beverage Establishment Inspection Report

Location:
Maple Woods Assisted Living
40170 County Road 257
Cohasset, MN55721
Itasca County, 31

Establishment Info:
ID #: 0038603
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189999072
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

Hot Water: = at >160F Degrees Fahrenheit
Location: WARE WASH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: BUTTER
Temperature: 40 Degrees Fahrenheit - Location: UPRIGHT FRIDGE
Violation Issued: No

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

DISCUSSION
ALL FOODS COOKED TO SERVE

GLOVES USED TO HANDLE READY TO EAT FOODS

ALL FOOD CONTACT SURFACES MUST BE SANTIZED BEFORE USED TO PREP FOODS

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 7939221113 of 06/06/22.

Certified Food Protection Manager: CARLA HODGSON

Certification Number: FM83342 Expires: 04/19/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

HANNAN H
COOK

Signed: _____

RYAN TRENBERTH
SAN III
BEMIDJI DISTRICT OFFICE
218-308-2133
ryan.trenberth@state.mn.us