



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 22, 2024

Licensee
Maple Care Homes
8997 Montequ Terrace
Brooklyn Center, MN 55443

RE: Project Number(s) SL37437015

Dear Licensee:

On October 8, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 19, 2024, survey were corrected. This follow-up survey verified that the facility is back in compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kelly Thorson'.

Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 14, 2024

Licensee
Maple Care Homes
8997 Montequ Terrace
Brooklyn Center, MN 55443

RE: Project Number(s) SL37437015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 19, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

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 may be 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.

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

1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

Maple Care Homes

August 14, 2024

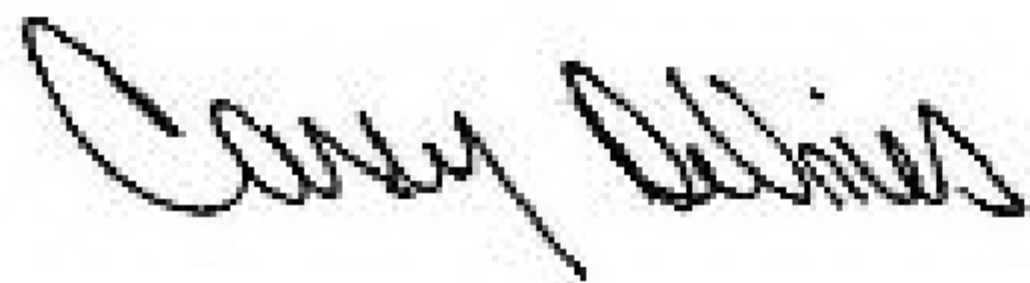
Page 3

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is written in a cursive, flowing style.

Casey DeVries, Supervisor

State Evaluation Team

Email: casey.devries@state.mn.us

Telephone: 651-201-5917 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
(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 *****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: SL37437015-0 On July 17, 2024, through July 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents all of whom received services under the provider's Assisted Living Facility license. An immediate order for correction was identified on July 18, 2024, issued for SL37437015-0, tag identification 1290. On July 19, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 250 SS=F	144G.20 Subdivision 1 Conditions	0 250			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 (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, 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, or interferes with or impedes access by the Office of Ombudsman for Mental Health and Developmental Disabilities according to section 245.94, subdivision 1; (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	0 250			

Minnesota Department of Health

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0 250	Continued From page 2 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. 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:	0 250			

Minnesota Department of Health

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0 250	Continued From page 3 During the entrance conference on July 17, 2024, at 9:26 a.m., licensed assisted living director (LALD)-D 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 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	0 250			

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0 250	Continued From page 4 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 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.	0 250			

Minnesota Department of Health

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0 250	Continued From page 5 - 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 LALD-D on October 3, 2024. The licensee had an assisted living license issued on February 1, 2024, with an expiration date of January 31, 2025. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies on employees; - orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; - implementation of the assisted living bill of rights; - infection control practices; and - medication and treatment management. On July 19, 2024, at 12:01 p.m., LALD-D confirmed the licensee provided assisted living services but failed to implement corresponding policies and procedures, as required.	0 250			

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0 250	Continued From page 6 As a result of this survey, the following orders were issued 0480, 0485, 0510, 0650, 0680, 0700, 0800, 0810, 1060, 1290, 1370, 1530, 1640, 1760, 1880, 1890, 1900, 1910, 1970, 2410, 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			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. 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 the residents).	0 480			

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0 480	Continued From page 7 The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 485 SS=C	144G.41 Subdivision 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 in advance of menu changes; and (C) the facility cannot require a resident to include and pay for meals in their contract; (ii) weekly housekeeping; (iii) weekly laundry service; This MN Requirement is not met as evidenced by: Based on observation, interview, and record	0 485			

Minnesota Department of Health

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0 485	Continued From page 8 review, the licensee failed to ensure the assisted living contract did not require any resident to include and pay for meals as a part of their assisted living package fee. In addition, the licensee failed to have a menu prepared at least one week in advance and made available to all residents. This had the potential to affect all residents of the facility. 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: CONTRACT On July 17, 2024, at 8:52 p.m., via email, licensed assisted living director (LALD)-D provided a blank contract titled Assisted Living Contract. The licensee's contract page included a section titled Primary Services and read, "Subject to the Resident's needs, Maple Care Homes will provide the following services which are included in the basic monthly fee: 1. Food Service: Three (3) meals/day are served in the dining area as planned and prepared by Maple Care Homes staff at the following times: 8:00 AM Breakfast 12:00 PM Lunch 5:00 PM Dinner Interval snacks at 10:00 AM, 2:00 PM, and 7:30 PM."	0 485			

Minnesota Department of Health

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0 485	Continued From page 9 The contract included verbiage to require residents to pay for their meals as part of their assisted living package fee. On July 19, 2024, at 9:48 a.m., LALD-D stated the blank contract was use for all residents who resided at the facility. LALD-D stated they were aware of the requirement, and they were unaware of why they worded the contract the way it was written above. In addition, LALD-D stated residents were able to opt out of a meal and purchase their own meals if they did not like what was begin offered. MENU On July 17, 2024, at approximately 10:22 a.m., during a facility tour, the surveyor did not observe a meal menu posting. On July 17, 2024, at 12:37 p.m., unlicensed personnel (ULP)-A stated the licensee normally posted a meal menu however, a menu has not been posted for a week. The surveyor inquired how the ULP knew what to make for meals. ULP-A stated they made what the residents liked. On July 17, 2024, at 12:46 p.m., administrative assistant/unlicensed personnel (AA/ULP)-E stated the licensee used alternating menus. AA/ULP-E verified a menu was not posted on the bulletin board and stated they believed someone removed the menu off the bulletin board. The licensee's Food service policy dated August 1, 2021, indicated menus were prepared one week in advance and made available to all residents. No further information was provided.	0 485			

Minnesota Department of Health

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0 485	Continued From page 10	0 485			
0 510 SS=E	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 establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for incontinent brief changes for two of four residents (R2, R3). 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).	0 510			

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NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES			STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443		
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0 510	Continued From page 11 The findings include: On July 17, 2024, at 1:41 p.m., the surveyor observed unlicensed personnel (ULP)-A and administrative assistant/unlicensed personnel (AA/ULP)-E complete perineal care on R3. The surveyor observed ULP-A remove tabs on the incontinent brief, lower the front of brief, and wipe R3's groin with a wipe. ULP-A asked R3 to assist AA/ULP-E to roll to the side, wiped R3's buttock from the back down to the vagina, removed the soiled brief, continued to wipe bowel movement off of R3's perineal area and buttock, sprayed R3's buttock with perineal spray, and exited the room to obtain a washcloth. Without removing gloves or performing hand hygiene, ULP-A reentered R3's room continued to clean R3's perineal region and buttock with a washcloth. Without removing gloves and performing hand hygiene, ULP-A applied a new brief, AA/ULP-E assisted R3 with rolling onto their back, ULP-A attached the incontinent briefs with the tabs, ULP-A and AA/ULP-E removed gloves, exited the room, both employees washed their hands in the kitchen sink down the hallway from R3's room. In addition to the hand hygiene infection control breeches, the surveyor observed incorrect methods to provide perineal care by wiping R3 from the buttock towards the vagina increasing the risk of a urinary infection. On July 17, 2024, at 1:56 p.m., the surveyor observed ULP-A and AA/ULP-E complete an incontinent brief change on R2. ULP-A did not remove their gloves and perform hand hygiene after removing the soiled incontinent brief prior to applying a new incontinent brief. On July 18, 2024, at 8:10 a.m., ULP-A stated when a resident had a bowel movement they	0 510			

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0 510	Continued From page 12 would apply two pairs of gloves, remove the first pair of gloves after cleaning the bowel movement, and then place the new incontinent brief. ULP-A stated they were trained to wipe from the vagina to the buttock. ULP-A stated they were not trained to double glove however, they double gloved because it could be "messy". Clinical nurse supervisor (CNS)-C stated ULP were trained on infection control upon hire. CNS-C stated ULP were trained on perineal care by watching a video and ULP demonstrated perineal care to the nurse through direct observation. CNS-C stated ULP were trained to wipe from the perineal region out to the buttock and to fold washcloth with each wipe. CNS-C stated they were unsure if ULP were trained to change gloves and perform hand hygiene during perineal cares. The CDC document titled Clinical Safety: Hand Hygiene for HealthCare Workers dated February 27, 2024, indicated gloves should be changed when soiled with blood or body fluids after a task, moving from work on a soiled body site to a clean body site on the same resident or if gloves look dirty after completing a task. The licensee's Infection Control policy dated August 1, 2021, indicated the licensee would observe the recommended precautions for home care [assisted living] as identified by the CDC. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			

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0 650	Continued From page 13	0 650			
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record contained the required content for one of three employees (unlicensed personnel (ULP)-A). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 650			

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0 650	Continued From page 14 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-A was hired on December 4, 2023, to provide direct cares for residents. On July 17, 2024, at 1:41 p.m., the surveyor observed ULP-A and administrative assistant/unlicensed personnel (AA/ULP)-E change R3's incontinent brief and provide perineal care. ULP-A's employee record lacked the following competency evaluations: - standby assistance techniques and how to perform them; - recording temperature, pulse, and respirations; - safe transfer techniques and ambulation; and - range of motion and positioning. On July 18, 2024, at 2:11 p.m., clinical nurse supervisor (CNS)-C stated RN-B completed a majority of the ULP training at the facility. On July 19, 2024, at 8:18 a.m., ULP-A stated the registered nurse (RN) completed the competency evaluation listed above when they were hired. On July 19, 2024, at 10:07 a.m., licensed assisted living director (LALD)-D stated they were unable to locate ULP-A's competency evaluations. On July 19, 2024, at 10:45 a.m., the surveyor inquired what competency evaluations the nurses completed on the ULP. RN-B stated they mostly	0 650			

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0 650	Continued From page 15 completed medication competency evaluations. The surveyor inquired about the evaluation listed above. RN-B stated they completed competency evaluations on the topics listed above and perineal care. RN-B stated they educate the ULP when they saw the tasks occurring however, they did not always document it. The licensee's Staff Competency policy dated August 1, 2021, read, "c. The following topics must be completed by a practical skills test: i. Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting ii. Safe transfer techniques and ambulation iii. Range of motion and positioning iv. Reading and recording temperature, pulse and respirations v. Administration of medications and treatments, as required vi. Other delegated tasks" In addition, the policy indicated no one may provide care to residents on behalf of the licensee before successfully passing the competency evaluations. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
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	0 680			

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0 680	Continued From page 16 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain a written emergency preparedness plan (EPP) with all the required content as defined in Appendix Z. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680			

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0 680	Continued From page 17 The findings include: The licensee's emergency disaster preparedness plan dated 2021 lacked evidence of the following required content: - develop strategies for addressing facility and community-based risks to include staffing surges/shortages and backup plans; and - a quarterly review of the missing resident plan. On July 17, 2024, at 3:07 p.m., administrative assistant/unlicensed personnel (AA/ULP)-E stated if the licensee had a staffing emergency, they would utilize staff from other sister facilities, although they did not have it documented anywhere in the EPP. AA/ULP-E stated the missing resident plan was reviewed annually, and they were unaware of the requirement to review the plan quarterly. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated the licensee would have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupted services. In addition, a disaster drill would be conducted at the residence at least annually and the results of the drill would be documented. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or	0 700			

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0 700	Continued From page 18 electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure personal health and medical information was kept private for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). These finding include: On July 17, 2024, at 1:07 p.m., during a facility tour the surveyor observed the following on or next to the bulletin board located near the dining room table in the common area: - a document titled Bathing Reminder and included R1, R2, R3, and R4's need for bathing assistance and scheduled days for bathing to be performed; and - a hanging file which included all four resident's names listed on the outside of the files. Inside the files included the following documents: - R2's resident profile which included	0 700			

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0 700	Continued From page 19 allergies, hospital, diagnoses, vaccine history, contact information, pharmacy, clinics, transportation, providers, insurance, medications, services, and vital signs; - R3's medical equipment copy and safety check instructions; and - R4's resident profile which included allergies, hospital, diagnoses, vaccine history, contact information, pharmacy, clinics, transportation, providers, insurance, medications, services, and vital signs. On July 18, 2024, at approximately 2:11 p.m., clinical director of nursing (CNS)-C stated confidential medical information should not be left in the open. CNS-C stated they did not observe anything in the open a "couple weeks ago." The surveyor explained the items listed above. CNS-C stated the profiles where there in case the resident needed to be sent into the hospital so the ULP could provide the information about the resident to the paramedic. On July 19, 2024, at 9:59 a.m., licensed assisted living director (LALD)-D stated medical information should not be left in the open. The surveyor showed LALD-D the postings on the wall. The surveyor observed LALD-D remove the posting on the wall. LALD-D stated they were aware of resident confidentiality and the hanging files located in the dining room were there in case of emergencies. The licensee's Resident Confidentiality policy dated August 1, 2021, indicated clinical and billing records were kept in a locked file not accessible to the public. No further information was provided.	0 700			

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0 700	Continued From page 20	0 700			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of 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 July 18, 2024, from 10:10 a.m. to 10:43 a.m., survey staff toured the home with the administrative assistant/unlicensed personnel (AA/ULP)-E, and from, 10:43 a.m. to 11:15 a.m.,	0 800			

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0 800	Continued From page 21 the AA/ULP-E was replaced with the licensed assisted living director (LALD-D) for the remaining home tour. On the home tour, survey staff observed the following: -The mechanical room floor was damp and had standing water throughout the room creating slippery conditions for residents and staff. Survey staff explained that there was also excessive water on the floor adjacent and around the perimeter of the furnace and water heater and that there may be a blockage in the condensate piping or some other leak issues that must be investigated and resolved. The AA/ULP-E acknowledged the condition as the AA/ULP-E stated that the mechanical room had just been mopped by one of their employees to remove water and agreed that the overflow may be related to the air conditioning. In addition, survey staff explained to the AA/ULP-E that the damp floor had the potential for an environment for mold growth and needed to be addressed promptly and properly. -The dryer vent duct was disconnected at a joint about four feet above the floor behind the dryer. The disconnected vent duct would prevent proper dryer exhaust to the outside for proper discharge. The AA/ULP-E acknowledged the finding and stated that they could have someone reconnected by the end of the day. -Missing window screens in resident sleeping rooms 2, 4, and 5. Survey staff stated the installation of the window screens will prevent insects from entering the home. The AA/ULP-E and survey staff observed dead flies on the windowsill of sleeping room 4 and the AA/ULP-E agreed that the flies came from not having window screens. The AA/ULP-E stated that the	0 800			

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0 800	Continued From page 22 window screens would be installed after noticing the screens in the mechanical room. -In the main level bedroom 1, the return air duct grill near the floor next to the bed/door was soiled and the toilet bowl was stained with dark spots that needed to be cleaned. In addition, the shower and the bathtub inside bedroom 1 master bathroom were explained by the AA/ULP-E that the plumbing fixtures were not used and the resident uses the central shower where the staff can assist with showering. At the time of discovery, survey staff explained to the AA/ULP-E that they must perform regular maintenance by running water to these plumbing fixtures to prevent sewer gas from entering the home. The AA/ULP-E agreed and verified the deficient finding. -No carbon monoxide alarms (CO) were provided on the main or lower-level floor near sleeping rooms. The LALD-D stated they had them and started to look for the CO alarms by opening the closets of the homes. On July 18, 2024, at 11:40 p.m., during the interview, survey staff explained to the LALD-D the above deficient findings. The LALD-D understood and acknowledged the findings. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and	0 810			

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0 810	Continued From page 23 maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on document review and interview, the licensee failed to provide all required contents on the fire safety and evacuation plan, the minimum number of fire evacuation drills, and the required minimum training of staff on the fire safety and	0 810			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 24 evacuation plan. This has the potential to directly affect the safety of visitors, staff, and all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 July 18, 2024, at 11:40 a.m. document review and interview with the licensed assisted living director (LALD)-D indicated the following: -A discrepancy between the fire safety movement on the evacuation floor plan and the evacuation report, dated August 18, 2023. The evacuation layout plan showed the entry door as the home's main designated exit however, the evacuation report noted residents incorrectly routed through the garage rather than the designated exit door. Survey staff explained to the LALD-D that the garage is considered a hazardous area and in addition, when there is a power failure, the garage overhead doors will not open for the residents to exit. The LALD-D concurred with the finding at the time of discovery as he explained that he would review and correct the exiting plan. -Additional documentation on employee fire safety training was received via email from the LALD-D on July 18, 2024, at 9:59 p.m. Record review indicated the licensee lack employee training on the facility fire safety and evacuation plan for the calendar year 2023. The fire training	0 810			

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0 810	Continued From page 25 records received included the correct training records for 2024, but no training records for 2023. - Additional documentation on fire drills was received via email from the LALD-D on July 18, 2024, at 3:57 p.m. The fire drill records provided for review indicated that the drills were meeting notes of scenarios and staff actions, rather than required fire evacuation drills performed by employees. In addition, the licensee lack employee fire drills for the first quarter of 2023. On July 18, 2024, at 11:40 p.m., survey staff requested for fire safety training and fire drill documentation but none were provided for review. The LALD-D stated they do have the fire drill and employee training records but not on-site . Survey staff stated that this citation will remain but additional documentation will be honored if received by 4:00 p.m. today (July 18, 2024). The LALD-D understood and acknowledged the findings. Additional information was received from the LALD-D via email on July 18, 2024, at 3:57 p.m. (drill documentation) and again at 9:59 p.m. (fire training documentation). TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060			

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01060	Continued From page 26 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060			

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01060	Continued From page 27 licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's Service Plan (Wavier)-Addendum to Contract signed March 31, 2023, indicated R1 received assistance with medication administration three times per day. R1's progress notes dated March 31, 2024, through April 4, 2024, indicated R1 was sent to the hospital on April 1, 2024, after a fall with injury and returned to the licensee on April 3, 2024. R1's record lacked evidence the licensee provided the resident or resident's representative a written emergency relocation notice. On July 18, 2024, at 11:55 a.m., the surveyor requested an emergency relocation notice for R1. Administrative assistant/unlicensed personnel (AA/ULP)-E stated, "no emergency relocation was performed." AA/ULP-E stated the licensee had not completed any emergency relocation notices for any resident who were hospitalized because they did not intend for the resident to not return to the facility. AA/ULP-E stated they	01060			

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01060	Continued From page 28 contact the resident's case worker if the resident is hospitalized for more than three days. On July 18, 2024, at approximately 2:11 p.m., the surveyor inquired if the licensee completed an emergency relocation notice for R1 or any resident who had been hospitalized. Clinical nurse supervisor (CNS)-C stated the emergency notice was located on the service plan that they signed upon admission. The surveyor attempted to review the statute with CNS-C. CNS-C again stated the emergency relocation was written on the service plan they sign at admission. The licensee's Discharge and Transfer of Residents policy dated August 1, 2021, read, "In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a. The resident b. The resident's legal representative c. The resident's designated representative d. If the resident receives home and community-based services, the resident's case manager e. If the resident has been relocated and not returned to Maple Care Homes Brooklyn Park within four (4) days, the Office of Ombudsman for Long-Term Care." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly	01290			

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01290	Continued From page 29 scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for seven of 13 employees (clinical nurse supervisor (CNS)-C, administrative assistant/unlicensed personnel (AA/ULP)-E, unlicensed personnel (ULP)-F, ULP-G, ULP- H, ULP-I, ULP-J). 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). The finding include: CNS-C CNS-C was hired on January 1, 2019, to provide	01290			

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01290	Continued From page 30 supervision to ULP and to provide direct care services to residents. CNS-C was licensed as a registered nurse on November 27, 2002. AA/ULP-E AA/ULP-E was hired on September 27, 2021, to assist with administrative tasks and provide direct care services to residents. On July 17, 2024, at 1:56 p.m., the surveyor observed AA/ULP-E assist with an incontinent brief change for R2. ULP-F ULP-F was hired on June 19, 2024, to provide direct care services to residents. ULP-F's Staff Activity Trail in RTasks (a documenting software program), indicated ULP-F logged in to RTasks last on July 4, 2024. ULP-G ULP-G was hired on January 1, 2019, to provide direct care services to residents. ULP-G's Staff Activity Trail in RTasks, indicated ULP-G logged in to RTasks last on May 10, 2024. ULP-H ULP-H was hired on June 18, 2024, to provide direct care services to residents. ULP-H's Staff Activity Trail in RTasks, indicated ULP-H logged in to RTasks last on July 17, 2024. ULP-I ULP-I was hired on May 4, 2022, to provide direct care services to residents.	01290			

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01290	Continued From page 31 On July 18, 2024, the surveyor observed ULP-I completing tasks around the facility. ULP-J ULP-J was hired on December 12, 2023, to provide direct care services to residents. ULP-J's Staff Activity Trail in RTasks, indicated ULP-J logged in to RTasks last on July 17, 2024. On July 17, 2024, at 3:56 p.m., the surveyor received the licensee's NETStudy 2.0 (web-based system used to submit background study requests) roster for health facility identification number (HFID#) 37437. The surveyor did not observe CNS-C, AA/ULP-E, ULP-F, ULP-G, ULP-H, ULP-I, ULP-J on the roster. The surveyor requested the company NETStudy 2.0 roster. On July 17, 2024, at 4:07 p.m., AA/ULP-E provided the surveyor with the licensee's corporate umbrella NETStudy 2.0 roster which contained all HFIDs under the corporate umbrella and the surveyor observed: - No background study completed for the following employees: - ULP-F; - ULP-G; and - ULP-I. - background studies completed affiliated to the licensee's sister facilities: - CNS-C affiliated to HFID# 30641; - AA/ULP-E affiliated to HFID# 30641 and 33109; - ULP-H affiliated to HFID# 30641; and - ULP-J affiliated to HFID# 33109. On July 17, 2024, at 4:15 p.m., AA/ULP-E stated the licensee attempted to run a background study	01290			

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01290	Continued From page 32 on ULP-F however, the computer system would not allow them to run the background study due to an issue with the birthdate. AA/ULP-E stated they have attempted to call "the state" and had not received assistance. AA/ULP-E stated they requested ULP-F show the licensee proof of a background study clearance prior to their employment start date. AA/ULP-E provided the surveyor a copy of a digital background study clearance letter. The surveyor observed a background clearance letter affiliated to HFID# 23592 for ULP-F. HFID# 23592 was not a sister facility of the licensee. AA/ULP-E stated ULP-F was scheduled to work next on July 18, 2024. AA/ULP-E stated ULP-F provided direct care however, worked with another person at all times because they were still in training. AA/ULP-E verified they did not see ULP-G on the company's NETStudy 2.0 roster. AA/ULP-E stated they believed a background study was completed for ULP-G however, they did not know because they were hired prior to AA/ULP-E's start date of employment. Licensed assisted living director (LALD)-D stated they completed a background study on ULP-G upon hire and believed the background clearance letter was located in the corporate office. LALD-D stated ULP-G had not worked in the facility since April because they were completing schooling. The surveyor observed the Minnesota Board of Nursing and did not observe ULP-G as a registered nurse. AA/ULP-E stated ULP-I was an on call ULP and worked one shift on June 8, 2024, two shifts last pay period, and AA/ULP-E did not know when they worked next. LALD-D stated ULP-I worked day shift and sometimes overnights. The surveyor inquired if the overnight shift had one or two ULPs working the shift. LALD-D stated one. On July 18, 2024, at 7:41 a.m., the surveyor	01290			

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01290	Continued From page 33 observed NETStudy2.0 for HFID# 37437 and observed no completed background study for ULP-F, ULP-G, ULP-I. On July 18, 2024, at 8:43 a.m., AA/ULP-E stated they were responsible along with LALD for background studies. AA/ULP-E stated if a ULP was hired and traveled to multiple facilities they would associate the ULP with the corporate office. If a ULP was hired for a specific facility, they would affiliate the ULP to the specific facility. The surveyor inquired if they would affiliate the ULP if they came from the corporate office to work at a specific facility. AA/ULP-E stated they would not change anything in NETStudy 2.0 however, they would grant that employee access in RTasks (a documenting software program). On July 18, 2024, at 8:58 a.m., AA/ULP-E provided the surveyor a background study clearance letter for ULP-G completed on January 21, 2021, affiliated with HFID#25215. AA/ULP-E stated it was the corporate office. On July 18, 2024, at 9:03 a.m., AA/ULP-E stated they were unable to access the HFID#25215 roster in NETStudy 2.0. AA/ULP-E stated HFID#25215 was the corporate office's HFID# prior to the transfer of ownership and when ownership was transferred the company changed their name and HFID#. The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated in accordance with applicable state and federal regulations, the licensee assures that all person were appropriately screened prior to employment. The criminal background check would be submitted to the department of human services (DHS) and would be maintained in the employee's personnel	01290			

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01290	Continued From page 34 file. No further information provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family;	01370			

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01370	Continued From page 35 (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed for all required skill areas, prior to providing services, for one of two unlicensed personnel (ULP)-A). 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: ULP-A was hired on December 4, 2023, to provide direct cares for residents. On July 17, 2024, at 1:41 p.m., the surveyor observed ULP-A and administrative assistant/unlicensed personnel (AA/ULP)-E change R3's incontinent brief and provide perineal care. ULP-A's employee record lacked the following competency evaluations:	01370			

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01370	Continued From page 36 - appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting. On July 19, 2024, at 8:18 a.m., ULP-A stated the registered nurse (RN) did not complete a competency evaluation of the topics listed above. On July 19, 2024, at 10:45 a.m., RN-B stated they completed mostly medication competency evaluations. The surveyor inquired about the evaluation listed above. RN-B stated they completed competency evaluations on the topics listed above and perineal care. RN-B stated they educate the ULP when they see the task occurring however, they did not always document it. The licensee's Staff Competency policy dated August 1, 2021, read, "c. The following topics must be completed by a practical skills test: i. Appropriate and safe techniques in personal hygiene and grooming, including bathing, hair care, oral hygiene (teeth, gums and oral prosthetics), care and use of hearing aids, dressing and toileting ii. Safe transfer techniques and ambulation iii. Range of motion and positioning iv. Reading and recording temperature, pulse and respirations v. Administration of medications and treatments, as required vi. Other delegated tasks" In addition, the policy indicated no one may provide care to residents on behalf of the licensee before successfully passing the competency evaluations.	01370			

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01370	Continued From page 37 No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01530 SS=E	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 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 interview and record review, the licensee failed to ensure direct care employees	01530			

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01530	Continued From page 38 received at least two hours training on topics related to dementia care for each 12 months of employment for two of three employees (registered nurse (RN)-B, unlicensed personnel (ULP)-I). 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: RN-B RN-B began employment with the licensee on October 3, 2022, to provide oversite to ULP and to provide direct care services to residents. RN-B's employee record included an EduCare (a training software) transcript dated July 18, 2024. The transcript indicated RN-B completed dementia care training in 2022, and February 2023. In addition, RN-B had two uncompleted dementia courses that would have counted for 1.75 hours of dementia care training assigned on April 30, 2024. ULP-I ULP-I began employment with the licensee on May 4, 2022, to provide direct care services to residents. ULP-I's employee record included an EduCare transcript dated July 19, 2024. The transcript	01530			

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01530	Continued From page 39 indicated ULP-I completed dementia care training in 2022, and in May and June of 2023. RN-B and ULP-I's employee records lacked two hours of dementia care training to be completed for every 12 months of employment. On July 19, 2024, at 10:51 a.m., RN-B stated they thought they took a dementia care course on EduCare in April or May of 2024. The surveyor showed RN-B the EduCare transcript. RN-B stated they must have completed only part of it. LALD-D stated dementia care training was only completed via EduCare and staff were to receive 2 hours annually. The licensee's Dementia Education policy dated August 1, 2021, indicated supervisors of direct care employees and direct care employees would complete at least two hours of education on topics related to dementia for each twelve months of employment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on	01640			

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01640	Continued From page 40 resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan 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 the service plan included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided for three of four residents (R1, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on March 31, 2023, and began receiving assisted living services.	01640			

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01640	Continued From page 41 R1's diagnoses included severe intellectual disability, dementia, anxiety disorder, and mood disorder. R1's Service Plan (Wavier)- Addendum to Contract signed March 31, 2023, indicated R1 received assistance with medication administration. R1's unsigned Service Plan (Wavier)-Addendum to Contract dated July 18, 2024, indicated R1 received assistance with ambulation, appointments, bathing, dressing, drinking, mobility, exercise, grooming, housekeeping, incontinent care, laundry, behavior management, meals, medication administration, vital signs, safety checks, shopping assistance, socialization, toileting, and transportation. R1's updated service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On July 18, 2024, at 11:15 a.m., the surveyor inquired if R1 received more services than medication administration. Administrative assistant/ unlicensed personnel (AA/ULP)-E stated they provided more assistance for R1, and the service plan was signed when R1 admitted to the facility prior to all the services being added. AA/ULP-E stated they remember taking a service plan to R1's guardian however, they did not receive the service plan back. The surveyor requested any documentation to demonstrate a new service plan was provided to or discussed with R1 when services where added. Although requested, the surveyor did not receive	01640			

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01640	Continued From page 42 documentation of the service plan update prior to exit. R3 R3 admitted to the licensee on June 1, 2023, and began receiving assisted living services. R3's diagnoses included cardiomyopathy (disease of the heart muscle making it difficult to pump blood), hemiparesis (partial weakness of one side of the body) affecting the right side, chronic heart failure, recurrent strokes, blindness to both eyes, and dementia. R3's unsigned Service Plan (Wavier) -Addendum to Contract with an effective date of July 18, 2024, indicated R3 received assistance with ambulation, bathing, dressing, grooming, housekeeping, incontinent care, laundry, behavior management, meals, medication administration, vital signs, safety check, skin care, specialized treatments, and wound care. R3's record lacked a service plan that included a signature or other authentication by the resident or resident's designated representative to document agreement on the services to be provided. On July 18, 2024, at 2:58 p.m., AA/ULP-E stated they did not have a signed service plan for R3. AA/ULP-E stated they believe the service plan was sent out for signature. The surveyor requested any documentation to demonstrate a service plan was provided to or discussed with R3. Although requested, the surveyor did not receive documentation of the service plan update prior to exit. R4 R4 admitted to the licensee on March 25, 2024, and began receiving assisted living services.	01640			

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01640	Continued From page 43 R4's diagnoses included diabetes and kidney failure with dialysis. R4's Service Plan (Waiver) - Addendum to Contract signed March 25, 2024, indicated R4 received assistance with medication administration. R4's unsigned Service Plan (Waiver)-Addendum to Contract with effective date of July 18, 2024, indicated R4 received assistance with activities, appointments, bathing, dressing, financials, grooming, housekeeping, incontinence care, laundry, behavior management, meals, medication administration, nail care, repositioning, vital signs, safety checks, shopping, socialization, transfers, and transport assistance. R4's updated service plan lacked a signature or other authentication by the resident or resident's designated representative indicating agreement on services to be provided when revisions occurred. On July 18, 2024, at 11:17 a.m., the surveyor inquired why R4 only had medication administration on their service plan. AA/ULP-E stated, "I can get it signed easily, I just have to take it to him. Surely we told him all the services, but you know this business has to be documented or it did not happen." On July 18, 2024, at 2:24 p.m., clinical nurse supervisor (CNS)-C stated they developed the service plan in RTasks (a documenting software program) and when a service plan was created, or a new service was added, AA/ULP-E would send the document for signature. CNS-C stated a	01640			

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01640	Continued From page 44 signature should be obtained for a new service plan or when revisions were made. On July 19, 2024, at 10:52 a.m., registered nurse (RN)-B stated the nurses created the resident's service plan and AA/ULP-E obtained the signatures from the residents or family members. In addition, RN-B stated when a new service was added they contacted the family to make them aware of the new service being provided. The surveyor inquired where they documented this. RN-B stated the progress notes. The surveyor requested progress notes for the resident's listed above. Although requested the surveyor did not receive documentation of the progress notes prior to the end of survey. The licensee's Service Plan policy dated August 1, 2021, indicated the initial service plan and any revisions were signed by a representative from the licensee and the resident or resident's representative, indicating agreement with the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01760 SS=F	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	01760			

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01760	Continued From page 45 administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure medications were documented after medication administration for three of three residents (R1, R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 admitted to the licensee on March 31, 2023, and began receiving assisted living services. R1's Service Plan (Wavier)- Addendum to Contract signed March 31, 2023, indicated R1 received assistance with medication administration. R2 R2 admitted to the licensee on September 30, 2022, and began receiving assisted living services.	01760			

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01760	Continued From page 46 R2's Service Plan (Private) - Addendum to Contract signed December 26, 2022, indicated R2 received assistance with activities, appointments, bathing, dressing, housekeeping, incontinent care, laundry, behavior, meals, medication administration, positioning, prosthetic device application, vital signs, safety check, shopping assistance, socialization, and therapeutic exercises. R4 R4 admitted to the licensee on March 25, 2024, and began receiving assisted living services. R4's unsigned Service Plan (Waiver)-Addendum to Contract date July 18, 2024, indicated R4 received assistance with activities, appointments, bathing, dressing, financials, grooming, housekeeping, incontinence care, laundry, behavior management, meals, medication administration, nail care, repositioning, vital signs, safety checks, shopping, socialization, transfers, and transport assistance. On July 18, 2024, at 7:35 a.m. through 7:56 a.m., the surveyor observed unlicensed personnel (ULP)-A administer oral medications. The surveyor observed ULP-A open RTasks (a documenting software program) to R4's electronic medication administration record (EMAR). ULP-A opened and poured medications from R4's mediset (preset medication container) into a medication cup, counted ten pills, and placed the medication cup to the side of them. The surveyor observed the EMAR and observed the following oral medications listed: amlodipine 10 milligrams (mg), carbidopa levodopa 25 mg/ 100 mg, Eliquis 5 mg, gabapentin 100 mg, losartan potassium 25 mg, rosuvastatin calcium	01760			

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01760	Continued From page 47 10 mg, sevelamer 2400 mg, and vit-cap. The surveyor then observed ULP-A open R1's EMAR. ULP-A opened and poured R1's mediset container into a medication cup, and counted eight pills. The surveyor observed the following medication on R1's EMAR: divalproex delayed release (DR) 500 mg, finasteride 5 mg, gabapentin 900 mg, olanzapine 20 mg, and tamsulosin 0.8 mg. ULP-A placed R1's medications on the dining room table. ULP-A brought R4's medications to them in their room for administration. ULP-A returned to the dining room table, picked up R1's medications, and administered R1's medications to them. ULP-A then completed a blood pressure on R2, documented the blood pressure in the EMAR, opened the medication section of the EMAR, opened and poured medications from R2's mediset container into a medication cup, counted 6.5 pills, poured cereal, took the medications to R2's room, boosted R2 in bed, and administered the medications. The surveyor observed the following medications on the EMAR Tylenol 650 mg, aspirin 81 mg, Eliquis 5 mg, metoprolol 12.5 mg, quetiapine 25 mg, and Senna Plus tablet. ULP-A then exited R2's room, walked to the kitchen, picked up the poured bowl of cereal, brought it to R2, exited R2's room again, placed gloves on hands to feed R1 and cleaned the face and hands of R1, removed gloves and washed hands. The surveyor observed ULP-A prepare medications for multiple residents at one time without completing documentation which could have led to mixing up resident medications increasing the risk for a potential medication error. On July 18, 2024, the surveyor asked ULP-A to open R1, R2, and R4's EMARs. The surveyor observed medications for R1, R2, and R4 were	01760			

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01760	Continued From page 48 not documented on as administered. ULP-A stated they did not document because the surveyor was present. The surveyor reminded ULP-A the instruction of the surveyor prior to the medication pass to follow their daily routine for medication administration. ULP-A stated normally they administer medication to one resident, provide breakfast, document on the medication administration, and then move to the next resident. ULP-A stated they were nervous. On July 18, 2024, at approximately 2:27 p.m., clinical nurse supervisor (CNS)-C stated staff were trained to count the amount of medication on the resident's EMAR, compare the number of medications to the resident's mediset, administer the medications to the residents, and then document the medications right after medication administration on the EMAR. The licensee's Medication Documentation policy dated August 1, 2021, indicated documentation of medication administration will be completed promptly. In addition, medication documentation would be complete accurate and legible. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
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.	01880			

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01880	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 18, 2024, from 7:12 a.m., to 8:00 a.m., the surveyor observed the following: - 7:12 a.m., ULP-A placed four preset mediset (preset medication containers) for four residents on the dining room table then attended to tasks in the kitchen. The dining room was visible from the kitchen. - 7:25 a.m., R1 sat down at the dining room table. The surveyor observed R1 pointing at and touching the medisets. The surveyor also observed ULP-A glancing between tasks at the dining room table. - 7:35 a.m., ULP-A prepared R1 and R4's medications. ULP-A then brought R4's medication to their room located down the hallway and administered R4's medication. The surveyor observed R1 still at the table, unsupervised, with the medisets. ULP-A returned to the dining room. - 7:45 a.m., ULP-A gathered blood pressure equipment located in the kitchen. ULP-A then walked to R2's room and obtained R2's blood	01880			

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01880	Continued From page 50 pressure. The surveyor observed the medisets and R1 at the dining table. ULP-A returned to the dining room table, prepared R2's medication, walked into R2's room located down the hallway, administered the medication to R2, and returned to the dining room table. The surveyor observed the medisets still at the dining room table with R1 present, unsupervised. On July 18, 2024, at 8:01 a.m., the surveyor inquired if ULP-A always placed all morning medications on the dining room table. ULP-A stated they kept them on the table while they passed medication. The surveyor explained to ULP-A the dangers of leaving medications on the table unsupervised. ULP-A stated they usually do not leave the medication on the dining room table, they normally leave them on the kitchen counter however, because the surveyor was there, they needed more working space that was why they placed them on the dining room table verses the kitchen counter. On July 18, 2024, at 2:28 p.m., clinical nurse supervisor (CNS)-C stated medication should not be left unattended. CNS-C medications should be poured into a medication cup from the mediset, taken by the resident, and documented on right away. The licensee's Storage/Control of Medications policy dated August 21, 2021, indicated when the licensee was providing storage of medications outside of the resident's private living space, all prescription drugs were securely locked in substantially constructed compartments according to manufactures instructions and only authorized personnel would have access to the medications.	01880			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37437	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/19/2024
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 8997 MONTEQUE TERRACE BROOKLYN CENTER, MN 55443			
(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
01880	Continued From page 51 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=F	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to discard expired medication for three of four residents (R1, R3, R4). In addition, the licensee failed to ensure time-sensitive medications were labeled with the date opened for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 17, 2022, at approximately 10:22 a.m., during a facility tour, the surveyor observed the licensee's medication cabinet where unlicensed	01890			

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01890	Continued From page 52 personnel (ULP) dispensed medication from. The single cabinet included two separate locked doors that contained two shelves per locked doorway. The surveyor observed the following: EXPIRED MEDICATIONS - R1 two bottles carbamide peroxide 6.5 percent (%) with an expiration date of March 9, 2024, and April 6, 2024; - R3 two card of loperamide 2 mg with an expiration date of July 2, 2024, nitroglycerin 0.4 mg with an expiration date of June 25, 2024; and - R4 two bottles of ready to use enema with an expiration date of March 1, 2024, and April 14, 2024. TIME SENSITIVE MEDICATIONS -R3 time sensitive medications opened without a date opened label: latanoprost ophthalmic solution 0.0005 %. On June 18, 2024, at 2:29 p.m., clinical nurse supervisor (CNS)-C stated if a medication was expired, they would typically communicate between the nurses and discard the medication. On June 19, 2024, at 10:33 a.m., registered nurse (RN)-B stated time sensitive medication should be labeled with a date open label so they know when to dispose of the medication. RN-B stated they were the ones who labeled the bottles and believed ULP opened a new bottle instead of using the bottles they had marked with a date open label. RN-B stated they reviewed the medication cabinet one time per month and disposed of expired medications. RN-B stated they placed the expired medications away from the mediset in the medication cabinet and ULP were trained only to use the medications located right next to the mediset up.	01890			

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01890	Continued From page 53 The manufactures instructions for latanoprost 0.0005 % dated August 2011, indicated once opened latanoprost may be stored at room temperature for up to six weeks. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, discontinued medications may be kept until the expiration dates if there was a possibility of resuming the medication and if not resumed before the expiration date it would be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01900 SS=D	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a prescription medication for one resident was not being saved for use by another, other than the resident prescribed for one of one resident (R4). 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	01900			

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01900	Continued From page 54 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R5 R5 admitted to the licensee on May 19, 2023, and expired (death) on June 2, 2023. R5's discharge summary did not include a medication disposition. On July 17, 2022, at approximately 10:22 a.m., during a facility tour, the surveyor observed the licensee's medication cabinets where unlicensed personnel (ULP) dispensed medication from and observed R5's trazodone 50 milligrams (mg) mixed in with R4's medications cards. In addition, there were six additional medications of R5's in R4's storage compartment but moved to the side. Administrative assistant/unlicensed personnel (AA/ULP)-E stated the medications were overflow medication the nurse did not destroy. R4 R4 admitted to the licensee on March 25, 2024, and began receiving assisted living services. R4's diagnoses included diabetes and kidney failure with dialysis. R4's unsigned Service Plan (Waiver)-Addendum to Contract with effective date of July 18, 2024, indicated R4 received assistance with activities, appointments, bathing, dressing, financials, grooming, housekeeping, incontinence care, laundry, behavior management, meals, medication administration, nail care, repositioning, vital signs, safety checks, shopping, socialization, transfers, and transport	01900			

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01900	Continued From page 55 assistance. R4's Med Admin Summary - Month dated July 2024 indicated R4 was prescribed trazodone 50 mg one time per day at bedtime and trazodone 50 mg was administered to R4 17 times in the month of July by the licensee's staff. The licensee's Medication Administration policy dated August 1, 2021, indicated no prescription drug supply for one resident may be used or saved for use by anyone other than the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900			
01910 SS=E	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given,	01910			

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01910	Continued From page 56 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication's name, strength, prescription number as applicable, quantity, date of disposition, to whom the medications were given, and names of staff and other individuals involved in the disposition for two of three residents (R5, 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: R5 R5 admitted to the licensee on May 19, 2023, and expired (death) on June 2, 2023. On July 17, 2022, at approximately 10:22 a.m., during a facility tour, the surveyor observed the licensee's medication cabinet where unlicensed personnel (ULP) dispensed medication from and observed R5's trazodone 50 milligrams (mg) mixed in with R4's medications cards. In addition, R5's medication cards containing olanzapine 2.5 mg, hydroxyzine pamoate 25 mg, venlafaxine	01910			

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01910	Continued From page 57 extended release (ER) 75 mg, prednisone 10 mg, olanzapine 5mg, and senna 8.6 mg were located in R4's medication compartment but were moved to the side. All of R5's medications had an expiration date of May 17, 2024, with the exception of senna which had an expiration date of May 18, 2024. Administrative assistant/unlicensed personnel (AA/ULP)-E stated the medications were overflow medication the nurse did not destroy. R5's Med Admin Summary-Month dated May 2023 indicated the licensee administered artificial tears, Vitamin D 2000 units (u), gabapentin 100 mg, pantoprazole delayed release (DR) 40 mg, polyethylene glycol 17 g, prednisone 10 mg, venlafaxine ER 225 mg, olanzapine 5 mg, Tylenol 325 mg -650 mg as needed (PRN), hydroxyzine 25 mg PRN, olanzapine 2.5 mg PRN, sennoside 8.6 mg to 17.2 mg, and trazodone 50 mg to R5. R5's discharge summary did not include a medication disposition. R6 R6 admitted to the licensee on December 30, 2023, and discharged to a sister facility on January 25, 2023. On July 17, 2024, at approximately 10:22 a.m., during a facility tour, the surveyor did not observe any of R6's medications within the facility. R6's Med Admin Summary dated January 2024 indicated the licensee administered artificial tears, ear drops 6.5 percent (%) solution, hydroxyzine 25 mg, lisinopril 5mg, meloxicam 7.5 mg, metformin ER 750 mg, Novolog mix flex pen 70/30, omeprazole DR 20 mg, valacyclovir 1 gram (g), venlafaxine ER 150 mg, venlafaxine 75	01910			

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01910	Continued From page 58 mg, olanzapine 15 mg, pravastatin 40 mg, quetiapine 200 mg, Victoza 18 mg/3 milliliter (ml) give 1.8 mg, oxybutynin ER 5 mg, acetaminophen 500 mg to 1000 mg PRN, and hydroxyzine 25 mg PRN. R6's discharge summary did not include a medication disposition. R5 and R6's medical record lacked a medication disposition of medication to include medication's name, strength, prescription number as applicable, quantity, date of disposition, to whom the medications were given, and names of staff and other individuals involved. On June 18, 2024, at 12:39 p.m., AA/ULP-E stated a registered nurse (RN) at a sister facility wrote them via text message they did not complete a medication disposition for R6 because "it was not a official discharge from [company name], it was an internal transfer." On June 18, 2024, at 2:29 p.m., clinical nurse supervisor (CNS)-C stated they used two nurses for medication disposition, and they completed this typically one time per year due to a low number of discharges. CNS-C stated if a medication was expired, they would typically communicate between the nurses and discard the medication. CNS-C state medication disposition was completed through RTasks (a documenting software program). CNS-C stated they would document the drug, prescription number, amount remaining, and witnesses. CNS-C stated there was no medication disposition for R6 because R6 discharged back to the sister facility when the emergency relocation ended, and they though it would be "ok" to transfer the medication back to the sister facility.	01910			

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01910	Continued From page 59 On June 19, 2024, at 10:30 a.m., RN-B stated they documented medication disposition in RTasks. RN-B stated RTasks required nurses to document the medication, prescription number, number of pills, how it was destroyed, when it was destroyed, and who destroyed the medications. RN-B stated they destroyed medications with one nurse using vinegar unless it was a narcotic, then it required two nurses. RN-B stated R5's medications were not destroyed timely because of computer issues and they were out on maternity leave. The licensee's Disposition and Disposal of Medications policy dated August 1, 2021, read, "5. Upon disposition, [licensee] will document the following information in the clinical record a. Name, strength and prescription number of medication, as applicable b. Quantity c. Method of disposition or to whom the medications were given d. Date of disposition e. Name(s)/signature(s) of staff or other individuals involved in disposition f. If applicable, to whom the medications were given" In addition, the policy indicated discontinued medications may be kept until the expiration dates if there was a possibility of resuming the medication and if not resumed before the expiration date it would be disposed of according to this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			

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01970	Continued From page 60	01970			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure there were prescriber's orders for treatments for one of one resident (R3) who received treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 admitted to the facility on June 1, 2023, and began receiving assisted living services. R3's Service Plan (Waiver)-Addendum to Contract dated July 18, 2024, indicated R3 received assistance with ambulation, bathing, dressing, grooming, housekeeping, incontinent cares, laundry, behavior, medication	01970			

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01970	Continued From page 61 management, vital sign monitoring, safety checks, skin care, and wound care. On July 18, 2024, at 2:04 p.m., the surveyor observed a gauze bandage around R3's right ankle. Unlicensed personnel (ULP)-A stated R3's wound was located on the outer ankle. R3's record included the following service: - wound care daily by the registered nurse (RN). Right ankle wound: cleanse the wound with moist gauze and pat dry with sterile gauze. Apply Iodosorb gel to the wound and cover with sterile gauze and abdominal pad dressing, change daily. R3's record lacked a prescriber's order for wound care to the right ankle. On July 18, 2024, at 2:36 p.m., clinical nurse supervisor (CNS)-C stated R3 developed a pressure injury while in the hospital. CNS-C stated wound care was provided to R3 daily and registered nurse (RN)-B managed R3's treatment orders. On July 18, 2024, at 3:05 p.m., RN-B stated R3 developed a pressure injury in the hospital and saw a wound clinic for the wound treatment plan. RN-B stated the provider order was located in a bag in R3's room with the wound supplies. The surveyor inquired if they verified there was a prescriber signature either electronic or handwritten. RN-B stated they did not look for a prescriber signature. On July 18, 2024, at 3:14 p.m., administrative assistant/unlicensed personnel (AA/ULP)-E provided the surveyor with a physical therapy wound care summary dated June 24, 2024, that lacked a prescriber or therapist's signature.	01970			

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01970	Continued From page 62 AA/ULP-E stated those where the orders provided. In addition, AA/ULP-E stated the licensee was attempting to get an outside agency to complete wound care for R3 however, there were issues with R3's Medicare. The licensee's Treatment and Therapy Management policy dated August 1, 2021, indicated the RN or licensed health professional would obtain orders or prescriptions for all treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
02410 SS=D	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 unless otherwise documented in the resident's service 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	02410			

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02410	Continued From page 63 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 perineal care for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 admitted to the licensee on September 30, 2022, and began receiving assisted living services. R2's diagnoses included aphasia (inability to speak well) following cerebral infarction (stroke), hemiplegia (one sided paralysis) effecting right side, contracture (permanent shortening and tightening of muscle fibers that reduces flexibility and makes movement difficult) of joint on multiple sites, hallucinations, and pain. R2's Service Plan (Private) - Addendum to Contract signed December 26, 2022, indicated R2 received assistance with activities,	02410			

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02410	Continued From page 64 appointments, bathing, dressing, housekeeping, incontinent care, laundry, behavior, meals, medication administration, positioning, prosthetic device application, vital signs, safety check, shopping assistance, socialization, and therapeutic exercises. On July 17, 2024, at 1:56 p.m., the surveyor observed administrative assistant/unlicensed personnel (AA/ULP)-E and unlicensed personnel (ULP)-A complete an incontinent brief change on R2 with the door open. The surveyor observed a clear view from R2's doorway to R3's room and observed R3 laying in the bed while R2 incontinent brief was being changed. On July 19, 2024, at 10:04 a.m., licensed assisted living director (LALD)-D stated resident doors should be shut for privacy when cares were being performed. The licensee's Minnesota Bill of Rights for Assisted Living Residents dated November 8, 2022, indicated residents had the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. In addition, privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: 07/20/24
Time: 12:00:00
Report: 1025241147

Food and Beverage Establishment Inspection Report

Page 1

Location:

Maple Care Homes
8997 Montequ Terrace
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0037633
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7636078373
ID #:

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

The following orders previously issued on 07/18/24 have NOT been corrected.

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
Provide a means of testing the quaternary ammonia sanitizer (chlorine kit provided)

Issued on: 07/18/24 *Comply By: 07/18/24*

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Remove the hollow enclosed base from the cabinets to reduce harborage conditions for pests.

Issued on: 07/18/24 *Comply By: 07/26/24*

No NEW orders were issued during this inspection.

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

Received images of irreversible TMD for dish machine
Confirmation of cleaning
Purchase of sanitizer and drying rack
Pest control invoice from Ecolab
Copy of CFPM certificate Cameo Anderson FM108935

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Maple Care Homes

Food and Beverage Establishment Inspection Report

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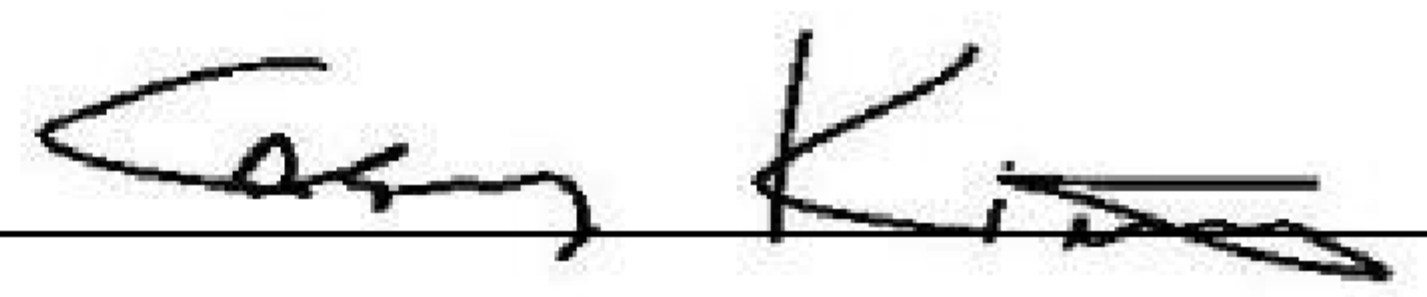
NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025241147 of 07/20/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Signed: _____
Establishment Representative

Signed:  _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 07/18/24
Time: 11:00:00
Report: 1025241113

Food and Beverage Establishment Inspection Report

Page 1

Location:

Maple Care Homes
8997 Montequ Terrace
Brooklyn Park, MN55443
Hennepin County, 27

Establishment Info:

ID #: 0037633
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7636078373
ID #:

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

The following orders were issued during this inspection.

4-700 Sanitizing Equipment and Utensils

4-702.11 **** Priority 1 ****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning. Utensils in sink washed and rinse and set to dry. Sanitize all utensils before drying and storage.

Comply By: 07/18/24

4-300 Equipment Numbers and Capacities

4-302.14 **** Priority 2 ****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions. Provide a means of testing the chemical sanitizer to be used to sanitize, plates,utensils, cabinet interiors, etc. (Search for test strips for bleach, quat ammonia, or the sanitizer to be used)

Comply By: 07/18/24

5-200C Plumbing: Maintenance, fixture location

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

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

Side of 2 compartment sink signed for handwashing used for drying utensils. Keep a sink basin clear for handwashing and use for no other purpose.

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2-100 Supervision

2-102.12DMN

MN Rule 4626.0033D Post the certified food protection manager certificate.

Post the CFPM certificate or copy at the establishment.

Comply By: 07/26/24

4-200 Equipment Design and Construction

4-202.17

MN Rule 4626.0545 Remove kick plates that are not designed to be easily removed for cleaning and inspection.

Mouse droppings observed, remove the hollow enclosed base from the cabinets to reduce harborage conditions for pests.

Comply By: 07/26/24

4-300 Equipment Numbers and Capacities

4-301.12C

MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.

Dish machine reported not operational during inspection. Use basins to complete the W/R/S of utensils until dish washer can be repaired.

Comply By: 07/18/24

4-300 Equipment Numbers and Capacities

4-303.11B

MN Rule 4626.0721B Provide chemical sanitizers to sanitize equipment and utensils during all hours of operation.

Provide a means of chemically sanitizing utensils in the establishment.

Comply By: 07/18/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.111ABD

MN Rule 4626.1565ABD Provide control of insects, rodents, and other pests by routinely inspecting incoming food and supply shipments; routinely inspecting the premises for evidence of pests; and eliminating harborage conditions.

Evidence of mice (droppings) inside the R side lazy susan. Clean area to allow for observation of any new issues. Provide control for pests. Store open food (potatos, onions, opened box of rice, etc) in pest proof containers.

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6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

Clean the interior of the R side lazy susan (mice) and the interior of the left side lazy susan (food oil leaked).

Clean and sanitize the interior of cabinets and the utensils stored inside R side lazy susan due to pest presence.

Comply By: 07/19/24

9-200 Special Events

9-200.01MMN

MN Rule 4626.1855M Provide space for air drying kitchenware, tableware, and utensils in the special event stand.

Provide space or a rack on the countertop for air drying of utensils. Drying utensils stored in the sink basin marked for handwashing.

Comply By: 07/18/24

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		1	2	7

FACILITY

Appliances are residential, solid surface counters, wood cabinets, tile backsplash

The sign on the refrigerator included instructions to keep handwashing sink clear and to sanitize the food sink after use. Provide a sanitizer for the food sink to use per these instructions. Some kitchen sprays exceed the 200-400 PPM quat ammonia for sanitizing, maintain a test kit to verify.

Dish machine not operational during inspection. Provide an alternate means of sanitizing. Discussed W/R/S using basins during inspection.

<https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf>

SINK USAGE

Facility has a two (2) compartment sink

Facility has a dishwasher with a sanitize cycle but was not in operation during inspection

Facility does not have a 3 compartment sink

Facility does not have a dedicated food preparation sink

COUNTERTOPS AND FOOD CONTACT SURFACES

Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed, and sanitized (e.g. run through the dishwasher). Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean without the use of substances which may damage the finish. Do not use wood as a food contact surface.

DISHWASHING – NSF 184

Dishwasher has a sanitizing rinse option (NSF/ANSI Standard 184) – use this option to sanitize utensils

Provide a means of testing the internal contact temperature of utensil in the dishwasher

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If the sanitize cycle on the dishwasher will not be used, provide an alternate means of chemical sanitizing (e.g. a bus tub or other basin, to be filled with water and sanitizing solution e.g. chlorine bleach (non-scented, labeled for Sanitizing Food Contact Surfaces) at 50-100 PPM; provide a test kit for chemical sanitizing)

Recommend having an alternative means of sanitizing available case of emergency or service interruption

As a temporary measure, until a dishwasher meeting the requirements of NSF Standard 184 or a 3 compartment sink is installed:

Provide 3 containers/bus tub/other basin for a chemical sanitizing (e.g. chlorine bleach 50-100 PPM or other chemical per label for sanitizing "food contact surfaces", submerge utensils for 1-2 minutes and air dry). Sanitize clean dishes and utensils in a container large enough to submerge the largest utensil. Provide an appropriate sanitizer for "food-contact surfaces" (label will include it as a heading) and an appropriate test kit. Wash, rinse, and sanitize utensils in these containers.

4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:

[...] (5) receptacles that substitute for the compartments of a multicompartment sink.

<https://www.nsf.org/consumer-resources/articles/dishwasher-certification>

EQUIPMENT

MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:

- (1) serves only non-TCS food; or
- (2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS

CFPM (Certified Food Protection Manager)

For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), chemical label, use, and storage, pest control, quarantine meals

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)

Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse

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Information on food recalls available "MDA Food Recall"

<https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota>

FACT SHEETS

Please search "MDH Fact Sheets" for the Food Business fact sheets page

"Cleaning and Sanitizing" <https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf>

"Food Cooking Temperatures"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf>

"Date Marking TCS foods"

<https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf>

"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs

<https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf>

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 1025241113 of 07/18/24.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____/____/____

Inspection report reviewed with person in charge and emailed.

Signed: _____

Establishment Representative

Signed: _____

Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us