Electronically Delivered

March 26, 2025

Licensee
Golden Maple Homes Inc.
13104 Girard Avenue South
Burnsville, MN 55337

RE: Project Number(s) SL32179016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 20, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

**STATE CORRECTION ORDERS**

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

**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:

**0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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**

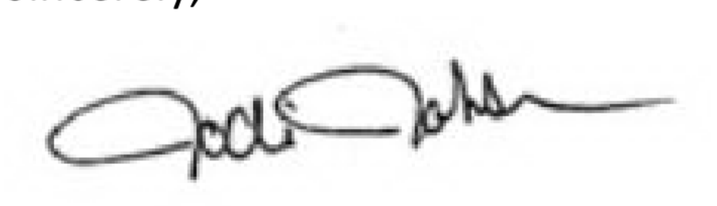
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: jodi.johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 32179 | A. BUILDING: _____ B. WING _____ | 02/20/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GOLDEN MAPLE HOMES INC | 13104 GIRARD AVENUE SOUTH BURNSVILLE, MN 55337 |

| (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 |
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| 0 000 | Initial Comments<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL32179016-0<br><br>On February 18, 2025, through February 20, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were four residents; four receiving services under the Assisted Living Facility license. | 0 000 | Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3. | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services | 0 480 | | |

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| 0 480 | Continued From page 1<br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation;<br>(2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570;<br>(3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage;<br>(4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink;<br>(5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are | 0 480 | | |

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| 0 480 | Continued From page 2<br><br>allowed provided the facility keeps them clean and in good condition;<br>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated February 18, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer | 0 480 | | |

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| 0 480 | Continued From page 3<br>to the FBEIR for any compliance dates. | 0 480 | | |
| 0 775 SS=F | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to comply with Minnesota State Fire Code, under Minnesota Rules Chapter 7511. This had the potential to directly affect all residents, staff, and visitors.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).<br><br>The findings include:<br><br>On February 20, 2025, at 1:20 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the tour, the surveyor observed the following:<br>CARBON MONOXIDE ALARMS<br>- Carbon monoxide alarms were not installed. Carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms<br>EXITING<br>- The egress windows were obstructed by the | 0 775 | | |

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| 0 775 | Continued From page 4<br><br>storage of personal items in front of the windows in resident sleeping rooms 2 and 3. Egress windows must be maintained free of obstruction.<br>- In the 2.04 Evacuation policy dated May 20, 2024, the building occupants were instructed to evacuate through the attached garage. Emergency exits are required to lead directly to the exterior of the building and not through a higher hazard room.<br>ELECTRICAL EXTENSION CORDS<br>- An extension cord was used to supply power to the refrigeration unit in the garage. The extension cord was attached to the garage wall and ran under the door and into the house where it was plugged into a wall outlet in the kitchen. Extension cords must not be used as a permanent power source. Extension cords are designed for temporary use only and using them improperly creates a fire hazard.<br>SMOKING MATERIAL DISPOSAL<br>- A small open shallow receptacle containing burnt cigarettes was stored in the garage. Containers used for the disposal of burnt smoking materials must be designed to extinguish cigarettes quickly and sized appropriately to contain the burnt smoking materials safely. The improper disposal of burnt smoking materials creates a fire hazard.<br>EQUIPMENT AND FACILITY MAINTENANCE<br>- There was an accumulation of lint behind the clothes dryer in the basement laundry room, creating a fire hazard.<br><br>During the facility tour interview on February 20, 2025, LALD/CNS-A, verified the above listed observations.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 775 | | |

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| 0 800 SS=D | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect a limited number of residents.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).<br><br>The findings include:<br><br>On February 20, 2025, at 1:20 p.m., the surveyor toured the facility with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the tour, the surveyor observed the toilet was soiled in the bathroom for occupied resident room 3. During the facility tour interview on February 20, 2025, LALD/CNS-A, stated the | 0 800 | | |

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| 0 800 | Continued From page 6<br>resident living in this room did not allow staff to come in the clean the bathroon and verified the above listed observation.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(f) Evacuation drills are required for staff 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 | 0 810 | | |

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| 0 810 | Continued From page 7<br>required to initiate the evacuation drill.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, record review, and interview, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors.<br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br>The findings include:<br>On February 20, 2025, licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.<br>FIRE SAFETY AND EVACUATION PLAN<br>The licensee failed to maintain the FSEP evident by the following:<br>The FSEP fire policy provided in the binder was dated July 1, 2021. During an interview on February 20, 2025, at 2:00 p.m., LALD/CNS-A stated this was not the current copy of the FSEP and verified the binder needed to be updated. LALD/CNS-A stated they would email the surveyor the updated FSEP.<br>On February 20, 2025, between 7:19 p.m. and 11:15 p.m., LALD/CNS-A emailed the surveyor updated copies of the FSEP procedures and policies. | 0 810 | | |

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| 0 810 | Continued From page 8<br><br>Based on record review, the FSEP inaccurately referenced smoke compartment doors, fire sprinklers, pull fire alarms, fire doors on magnetic holders, and a system wired to the fire station. On February 20, 2025, at 10:30 a.m., the surveyor toured the facility with manager (M)-B. During the tour, the surveyor observed that none of these life safety systems were installed in the facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 01060 SS=F | 144G.52 Subd. 9 Emergency relocation<br><br>(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.<br>(b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum:<br>(1) the reason for the relocation;<br>(2) the name and contact information for the location to which the resident has been relocated and any new service provider;<br>(3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;<br>(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<br>(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 | 01060 | | |

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| 01060 | Continued From page 9<br><br>information for the agency to which the resident may submit an appeal.<br>(c) The notice required under paragraph (b) must be delivered as soon as practicable to:<br>(1) the resident, legal representative, and designated representative;<br>(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and<br>(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.<br>(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<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br><br>The findings include:<br><br>R1's start of care was July 17, 2023, with diagnoses including type II diabetes. | 01060 | | |

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| GOLDEN MAPLE HOMES INC | 13104 GIRARD AVENUE SOUTH BURNSVILLE, MN 55337 |

| (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 |
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| 01060 | Continued From page 10<br><br>R1's Service Plan signed August 1, 2024, indicated R1 received services including medication set-up and administration, blood glucose monitoring, assistance with bathing, grooming, dressing, incontinence care, transfers, shopping, housekeeping, and laundry.<br><br>R1's hospital discharge orders dated February 9, 2025, indicated R1 was admitted to the hospital on February 4, 2025, and was discharged on February 9, 2025.<br><br>R1's record lacked a written notice that contained, at a minimum:<br>- the reason for the relocation;<br>- the name and contact information for the location to which the resident has been relocated and any new service provider;<br>- contact information for the Office of Ombudsman for Long-Term Care;<br>- 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<br>- 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.<br><br>On February 18, 2025, at 1:47 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated a written notice related to R1's emergency relocation had not been completed, and further lacked notification to the Office of Ombudsman for Long-Term Care that R1 had been relocated and had not returned to the facility within four days. LALD/CNS-A stated | 01060 | | |

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| 01060 | Continued From page 11<br>being unaware of this requirement.<br><br>The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated:<br>1. In the event of an emergency relocation, the licensee will provide a written notice that contains, at a minimum:<br>a. The reason for the relocation<br>b. The name and contact information for the location to which the resident has been relocated and any new service provider<br>c. Contact information for the Office of Ombudsman for Long-Term Care<br>d. 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<br>e. A statement that ,if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal.<br>3. The facility will provide contact information for the agency to which the resident may submit an appeal.<br>4. The notice required will be delivered as soon as practicable to:<br>a. The resident, legal representative, and designated representative<br>b. For residents who receive home and community-based waiver services, the resident's case manager, and<br>c. The Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days.<br><br>No further information was provided.<br><br>TIME PERIOD TO CORRECT: Twenty-one (21) days | 01060 | | |

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| 01730 | Continued From page 12 | 01730 | | |
| 01730 SS=D | 144G.71 Subd. 5 Individualized medication management plan<br><br>(a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>(1) a statement describing the medication management services that will be provided;<br>(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;<br>(3) documentation of specific resident instructions relating to the administration of medications;<br>(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;<br>(5) identification of medication management tasks that may be delegated to unlicensed personnel;<br>(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and<br>(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.<br>(b) The medication management record must be current and updated when there are any changes. | 01730 | | |

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| 01730 | Continued From page 13<br><br>(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop an individualized medication management plan with the required content for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>During the entrance conference on February 18, 2025, at 11:44 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the residents at the facility.<br><br>R1's diagnoses type II diabetes, congestive heart failure, hypertension, and shortness of breath.<br><br>R1's Service Plan signed August 1, 2024, indicated services included medication set-up and medication administration.<br><br>R1's hospital discharge orders dated February 9, 2025, included two insulin medications, three | 01730 | | |

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| 01730 | Continued From page 14<br><br>cardiac, two inhalers, one diuretic (water pill), one eye drop, one potassium supplement, two vitamins, and once calcium supplement.<br><br>On February 19, 2025, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-B obtaining R1's medications for administration from a locked cabinet in the kitchen area of the facility. The medications had been previously set up in a weekly medication pill box.<br><br>R1's Medication/Treatment/Therapy Management Plan dated July 17, 2023, indicated:<br>Medications will be:<br>- Controlled substances and PRN (as needed) medications are securely stored by the provider in a locked central storage in nursing office and can be accessed by provider staff.<br>- Stored in the client's (resident) unit located: in a locked medication box and are secure.<br><br>On February 19, 2025, at 12:50 p.m., LALD/CNS-A stated all R1's medications (other than refrigerated insulin pens) were secured in the locked cabinet in the kitchen area of the facility. LALD/CNS-A reviewed R1's medication management plan and stated R1 kept no medications in her room.<br><br>The licensee's 7.03 Medication Management Individualized Plan policy dated August 1, 2021, indicated:<br>1. Licensee will develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:<br>b. A description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. | 01730 | | |

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| 01730 | Continued From page 15<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01730 | | |
| 01750 SS=D | 144G.71 Subd. 7 Delegation of medication administration<br><br>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:<br>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and<br>(3) communicated with the unlicensed personnel about the individual needs of the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for an as needed (PRN) medication for one of one resident (R1) whose medication administration was delegated to unlicensed personnel.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or | 01750 | | |

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| 01750 | Continued From page 16<br><br>a limited number of staff are involved or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R1's 90-day RN assessment dated November 18, 2024, indicated R1 needed full medication management and set up with staff administering medications.<br><br>R1's Service Plan signed August 1, 2024, indicated services included medication administration by unlicensed personnel (ULP).<br><br>R1's hospital discharge orders dated February 9, 2025, included an order for torsemide (diuretic/water pill) 20 milligrams by mouth daily as needed for weight gain.<br><br>R1's February 2025, medication administration record (MAR-incorrectly dated March 2025) included the above order. The MAR did not include directions to staff on when to administer the medication related to weight gain.<br><br>On February 19, 2025, at 10:02 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R1's PRN torsemide order did not include parameters on weight gain directing when to administer the medication.<br><br>The licensee's 6.14 Delegation of Assisted Living Services policy dated August 1, 2021, indicated: 3. The registered nurse or licensed heath professional will document instructions for the delegated tasks in the resident's record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) | 01750 | | |

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| 01750 | Continued From page 17<br>days | 01750 | | |
| 01760 SS=E | 144G.71 Subd. 8 Documentation of administration of medication<br><br>Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure the medication administration record (MAR) was labeled accurately with the correct month and year for one of one resident (R1); failed to ensure medication orders were transcribed correctly for one of two residents (R1), and failed to ensure medication procedures were followed for one of two residents (R2) observed during medication administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a | 01760 | | |

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| 01760 | Continued From page 18<br><br>limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1<br>R1's diagnoses type II diabetes, congestive heart failure, hypertension, and shortness of breath.<br><br>R1's Service Plan signed August 1, 2024, indicated services included medication set-up and medication administration.<br><br>On February 18, 2025, at 1:34 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided the surveyor with R1's current medication administration record (MAR); the MAR was dated March 2025. LALD/CNS-A stated R1's current MAR was dated in error.<br><br>R1's hospital discharge orders dated February 9, 2025, included:<br>- insulin glargine 100 unit/ml (milliliter) pen. Inject 50 units subcutaneously (SQ) two times daily<br>- torsemide (diuretic/water pill) 20 mg (milligram). Take 60 mg (3 tablets) by mouth two times daily at 8:00 a.m. and 2:00 p.m.<br><br>R1's February 2025, MAR (incorrectly dated March 2025) included the following transcribed orders:<br>- insulin Basaglar (insulin glargine) 100 unit/ml injection SQ, inject 80 (crossed off with a line through it and the number 50 written under it) units twice a day<br>- torsemide 20 mg tablet, take three tabs (60 mg) by mouth in the morning and two tabs (40 mg) at 2:00 p.m. The documentation for the 2:00 p.m. | 01760 | | |

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| 01760 | Continued From page 19<br>dose indicated the same.<br><br>On February 19, 2025, at 9:43 a.m., LALD/CNS-A stated R1's basaglar insulin order had changed upon discharge from the hospital; she did not transcribe a new order and just crossed off the previous dosage and wrote in the new 50 unit dose. LALD/CNS-A further stated the MAR did not indicate the date the dosage had been changed. Upon further review of the MAR, LALD/CNS-A stated the MAR did not reflect the dosage increase for R1's 2:00 p.m. torsemide, although she had set it up correctly. The surveyor and LALD/CNS-A observed R1's 2:00 p.m. medication set-up for the current week and the torsemide was set up correctly.<br><br>The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated August 1, 2021, indicated the licensee will create and maintain a correct and accurate medications and /or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies.<br><br>The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated:<br>1) The RN (registered nurse) is responsible for assuring that:<br>a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the resident's records.<br><br>R2<br>R2's diagnoses included diabetes and nausea.<br><br>R2's Service Plan signed August 1, 2024, included medication set-up and administration.<br><br>R2's MAR dated February 2025, included: | 01760 | | |

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| 01760 | Continued From page 20<br><br>meclizine (antihistamine) 25 mg, take 1/2 (one half) tablet by mouth every morning for nausea.<br><br>On February 19, 2025, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)- B administering medications to R2 including the meclizine. ULP-B obtained the set-up medications from the medication pill box and counted them according to what was set-up on the first page of R2's MAR. The count from the first page of the MAR indicated 12 pills had been set-up for administration; ULP-B counted 13 pills and could not figure out the discrepancy. The surveyor turned to the third page of the MAR and located the order for R2's meclizine; the meclizine had only been signed off as administered one out of 18 days.<br><br>On February 19, 2025, at 10:02 a.m., LALD/CNS-A stated staff should ensure all medications administered from the medication set-up are documented/signed off as given.<br><br>The licensee's 2.37 Resident Record - Documentation policy dated August 1, 2021, indicated:<br>1. Staff providing assisted living services will document, daily, medications, services, treatments, or therapies provided to resident.<br>2. All documentation must include the signature and title of the person who performed the service or administered the medication, treatment or therapy. Initials may be used if there is a completed signature page included in the documentation.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01760 | | |

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| 01820 SS=D | 144G.71 Subd. 13 Prescriptions<br><br>There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure a current written or electronically recorded prescription was obtained for all medications the provider had managed for one of two residents (R2) observed during medication administration.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).<br><br>The findings include:<br><br>R2's record lacked signed prescriber orders for one medication set up for administration by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A.<br><br>R2's diagnoses included diabetes and anxiety.<br><br>R2's Service Plan signed August 1, 2024, included medication set-up and administration.<br><br>On February 19, 2025, at 8:25 a.m., the surveyor | 01820 | | |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOLDEN MAPLE HOMES INC | 13104 GIRARD AVENUE SOUTH BURNSVILLE, MN 55337 |

| (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 |
|---|---|---|---|---|
| 01820 | Continued From page 22<br><br>observed unlicensed personnel (ULP)-B preparing R2's morning medications for administration from a medication pill box that had been previously set-up by LALD/CNS-A. The medications included meclizine (used to prevent and control nausea, vomiting, and dizziness) 25 milligrams, take one-half tablet by mouth every morning for nausea.<br><br>R2's record lacked a physician order for meclizine.<br><br>On February 19, 2025, at 8:16 p.m., the surveyor received an email from LALD/CNS-A indicating R2's record did not include an order for meclizine. The email further indicated LALD/CNS-A had checked with the pharmacy who indicated the meclizine order on file was PRN (as needed) and not scheduled daily.<br><br>The licensee's 7.20 Medication & Treatment Orders policy dated August 1, 2021, indicated:<br>1) The RN (registered nurse) is responsible for assuring that:<br>a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01820 | | |
| 01890 SS=E | 144G.71 Subd. 20 Prescription drugs<br><br>A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription | 01890 | | |

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| 01890 | Continued From page 23<br><br>label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label and included the date opened of a time-sensitive drug for two of two residents (R1, R2) receiving insulin/antidiabetic medication.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).<br><br>The findings include:<br><br>R1<br>R1's diagnoses included diabetes.<br><br>R1's Service Plan signed August 1, 2024, indicated services included medication set-up and medication administration.<br><br>R1's hospital discharge orders included:<br>- insulin glargine 100 unit/milliliter (ml) pen, inject 50 units subcutaneously two times daily, and<br>- Novolog Flexpen 100 unit/ml insulin per sliding scale. Inject subcutaneously three times daily (with meals).<br>-BG (blood glucose) 150-199 = 6 units | 01890 | | |

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| 01890 | Continued From page 24<br><br>-BG 200-249 = 12 units<br>-BG 250-299 = 18 units<br>-BG 300-349 = 24 units<br>-BG 350-399 = 30 units<br>-BG 400 and above = 36 units<br><br>R2<br>R2's diagnoses included diabetes.<br><br>R2's Service Plan signed August 1, 2024, included medication set-up and administration.<br><br>R2's provider orders dated November 6, 2024, included:<br>- Basaglar 100 unit/ml Kwikpen (insulin). Inject 45 units subcutaneously once daily<br>- Victoza 18 milligrams/3 ml injection (antidiabetic medication). Inject 1.8 mg subcutaneously once daily.<br><br>On February 18, 2025, at 12:41 p.m., the surveyor toured the residence with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. LALD/CNS-A unlocked a cabinet in the kitchen area that contained all residents' medications. The surveyor observed R1's Novolog and Basaglar (insulin glargine) opened insulin pens and R2's open Basaglar and Victoza pens. None of the four pens had a current original pharmacy label or an opened date on the pen. LALD/CNS-A stated the pharmacy did not provide a label for each individual insulin pen though there was a label on the box the pens came in. LALD/CNS-A further stated the pens were not dated when opened because they always ran out before they expired.<br><br>The licensee's 7.13 Medications - Prescription Drugs & Prohibition policy dated August 1, 2021, indicated: When the licensee receives a | 01890 | | |

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|---|---|---|---|---|
| 01890 | Continued From page 25<br><br>prescription drug, prior to being set up for immediate or later administration, the prescription drug 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.<br><br>The Novolog insulin manufacturer's package insert revised February 2023, indicated Novolog FlexPen insulin expires 28 days after opening.<br><br>The Basaglar KwikPen Instructions for Use package insert revised August 26, 2022, indicated: Throw away the Pen you are using after 28 days, even if it still has insulin left in it.<br><br>The Victoza manufacturer's package insert revised November 2024, indicated after first use of the Victoza pen, the pen can be stored for 30 days at controlled room temperature or in a refrigerator.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy | 01940 | | |

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| 01940 | Continued From page 26<br><br>management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1).<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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). | 01940 | | |

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| 01940 | Continued From page 27<br><br>The findings include:<br><br>During the entrance conference on February 18, 2025, at 11:44 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment management services to residents, including assistance with blood glucose monitoring.<br><br>On February 19, 2025, at 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-B administering medication to R1.<br><br>R1's Service Plan signed August 1, 2024, included blood glucose checks three times a day and as needed.<br><br>R1's hospital discharge orders included Novolog Flexpen insulin per sliding scale. Inject subcutaneously three times daily (with meals).<br>-BG (blood glucose) 150-199 = 6 units<br>-BG 200-249 = 12 units<br>-BG 250-299 = 18 units<br>-BG 300-349 = 24 units<br>-BG 350-399 = 30 units<br>-BG 400 and above = 36 units<br><br>R1's February 2025, medication administration record (MAR - incorrectly dated as March 2025) included the above order. The MAR directed staff to hold insulin if blood glucose was less than 100.<br><br>R1's record lacked a treatment management plan that was individualized to include procedures for notifying a RN when a problem arose with specific criteria on when to notify the RN.<br><br>On February 19, 2025, at 10:02 a.m., licensed assisted living director/clinical nurse supervisor | 01940 | | |

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| 01940 | Continued From page 28<br><br>(LALD/CNS)-A stated R1's record did not include parameters for blood sugars on when to notify a nurse.<br><br>The licensee's 7.05 Treatment & Therapy Management Plan policy dated August 1, 2021, indicated the licensee will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01940 | | |
| 02290 SS=F | 144G.91 Subd. 2 Legislative intent<br><br>The rights established under this section for the benefit of residents do not limit any other rights available under law. No facility may request or require that any resident waive any of these rights at any time for any reason, including as a condition of admission to the facility.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee limited the rights of four of four residents (R1, R2, R3, R4) when the licensee required the resident or their representative to sign a Resident Agreement.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 02290 | | |

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| 02290 | Continued From page 29<br><br>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).<br><br>The findings include:<br><br>Upon entrance into the residence on February 18, 2025, at 11:30 a.m. the surveyor observed a posting titled, Courtesy House Rules. The posting included the following:<br>- Visiting hours are from 9:00 a.m. to 8:00 p.m., seven days a week.<br>- Our day starts at 8:00 a.m.<br>- All residents must be ready for bed and in their rooms by 10:00 p.m.<br><br>On February 19, 2025, at 9:21 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated staff were available to residents 24 hours a day, seven days a week. LALD/CNS-A further stated the posted visiting hours and bedtime expectation were a rights violation. LALD/CNS-A then removed the posting.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 02290 | | |

Minnesota Department of Health
Environmental Health, FPLS
P.O Box 64975
Saint Paul
651-201-4500

Type: Full
Date: *02/18/25*
Time: 08:50:49
Report: 1018251026

# Food and Beverage Establishment Inspection Report



**Location:**
Golden Maple Homes Inc
13104 Girard Avenue South
Burnsville, MN55337
Dakota County, 19

**Establishment Info:**
ID #: 0039209
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9523933690
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.

**3-300B Protection from Contamination: cross-contamination, eggs**

***3-302.11A(1)*** ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS OBSERVED TO BE STORED OVER READY TO EAT FOODS IN THE FRIDGE. CORRECTED ON SITE.

*Corrected on Site*

**Surface and Equipment Sanitizers**

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

**Food and Equipment Temperatures**

Process/Item: Cold Holding/ CHEESE
Temperature: 40 Degrees Fahrenheit - Location: FRIDGE
Violation Issued: No

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

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

ESTABLISHMENT IS DOING ALL SAME DAY SERVICE OF FOODS.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN FAIR CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK AND ONE SINK SPECIFICALLY FOR HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE. TEST STRIP INDICATED APPROPRIATE TEMPERATURE WAS ACHIEVED DURING CYCLE.

ESTABLISHMENT HAS A NEEDLE POINT THERMOMETER FOR CHECKING FOOD TEMPERATURES.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED EMPLOYEE ILLNESS LOG.

**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 1018251026 of 02/18/25.

Certified Food Protection Manager: CAROL FILLMORE

Certification Number: FM110730 Expires: 03/07/25

**Inspection report reviewed with person in charge and emailed.**

Signed: _____

CAROL FILLMORE
MANAGER

Signed: _____

Rebecca Prestwood
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rebecca.prestwood@state.mn.us