Electronically Delivered

July 21, 2023

Licensee
Maplewood Care Residence
2338 Overlook Circle
Maplewood, MN 55119

RE: Project Number(s) SL25791016

Dear Licensee:

On July 7, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 11, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

Electronically Delivered

May 18, 2023

Licensee
Maplewood Care Residence
2338 Overlook Circle
Maplewood, MN 55119

RE: Project Number(s) SL25791016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 13, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, the MDH noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. Chapter 260E.

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

In accordance with Minn. Stat. § 144A.474,Subd. 11, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey at your agency**.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(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 client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(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. § 144A.474, Subd. 12, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the MDH within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144A.44 Subd. 1(14), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

Please email reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

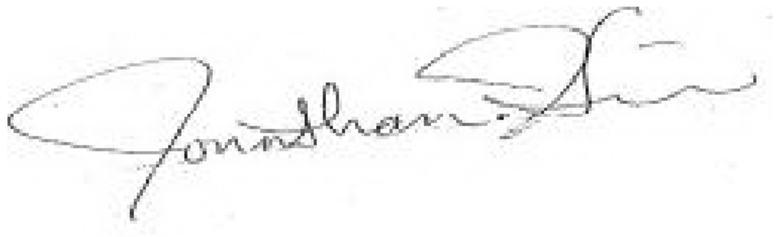
Please address your cover letter for reconsideration requests to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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,



Jonathan Hill, Supervisor
State Evaluation Team
Email: jonathan.hill@state.mn.us
Telephone: 651-201-3993 Fax: 651-281-9796

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25791	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE RESIDENCE	2338 OVERLOOK CIRCLE MAPLEWOOD, MN 55119

(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: SL25791016 On April 10, 2023 through April 13, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were six active residents; five receiving services under the Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
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	0 480		

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0 480	Continued From page 1 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). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated, April 10, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for	0 550		

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0 550	Continued From page 2 Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post the required information related to the grievance procedure and contact information for the Office of Ombudsman for Long-Term Care and Mental Health and Developmental Disabilities; as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 clients). The findings include: On April 10, 2023, during a facility tour at 3:00 p.m., an observation was made of the facility's common area and noted to lack the required posting of the grievance procedure and information related to reporting suspected maltreatment to MAARC.	0 550		

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0 550	Continued From page 3 The licensee lacked a posting of the grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. In addition, there was no evidence of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, or any information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). On April 11, 2023, at 12:00 p.m., licensed practical nurse (LPN)-C stated the required posting were "not where they used to be." LPN-C further stated, "they used to be laminated and on the wall." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and	0 790		

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0 790	Continued From page 4 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the required portable fire extinguisher in accordance with the Minnesota State Fire Code as required by MN Statute 144G.45 subd.2(a)(2). This had the potential to directly affect the safety of the residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: On April 11, 2023, approximately from 1:20 p.m. to 2: 20 p.m., survey staff toured the home with the licensed practical nurse (LPN)-C. During the tour, survey staff observed and the LPN-C visually and/or verbally verified the portable fire extinguishers were not annually serviced by an authorized professional to maintain the extinguishers in proper working order. The findings were evident as the extinguishers were tagged with an annual service record of December 2021 and the laundry portable fire extinguisher with a tag of annual service date of February 2022. On April 11, 2023, at approximately 3:20 p.m., at the exit interview, survey staff explained to the	0 790		

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0 790	Continued From page 5 LPN-C that portable fire extinguishers must be serviced annually and monthly quick inspections must also be performed to ensure the proper functioning of the units. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 800		

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0 800	Continued From page 6 The findings include: On April 11, 2023, approximately from 1:20 p.m. to 2: 20 p.m., survey staff toured the home with the licensed practical nurse (LPN)-C. During the tour, survey staff observed and the LPN-C visually and/or verbally verified the following: 1.The egress windows of bedrooms #1, #3, and #6 were difficult to open when the LPN-C attempted to open the windows. The LPN-C asked for assistance from staff while attempting to open bedroom #3. Survey staff explained to the LPN-C that all egress windows and window hardware in bedrooms must be always easily openable for immediate use including during an emergency. 2.Provide an approved smoke receptor for outdoor designated smoking for staff. Survey staff observed the LPN-C smoking on the side of the house without an approved smoke receptor. 3.The door into the garage had a sign incorrectly labeled as the home's primary exit door. The garage is considered a hazardous area and must not be used or labeled as the primary exit. On April 11, 2023, at approximately 3:20 p.m., at the exit interview, the LPN-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment	0 810		

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0 810	Continued From page 7 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to provide the required complete documentation on fire safety and evacuation plans and evacuation drills. This has the potential	0 810		

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0 810	Continued From page 8 to directly affect the safety of 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). The findings include: On April 11, 2023, at approximately 2:30 p.m., the licensed practical nurse (LPN)-C provided survey staff with the facility fire safety and evacuation plan and related documentation for review. At approximately 3:00 p.m., a document review and interview with the LPN-C on the fire safety and evacuation plan indicated the following: 1. Document review indicated that the fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. Unique resident situations during an evacuation may be residents who have mobility limitations, are non-ambulatory, bedridden, have a cognitive impairment, or any residents needing assistance during an evacuation, and must be addressed in the fire safety and evacuation plan documentation. 2. Document review indicated that the fire safety and evacuation plan lacked fire protection procedures for residents. 3. Document review and observation indicated	0 810		

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0 810	Continued From page 9 the posted floor plan layout incorrectly showed the garage door through the laundry room as the primary exit. 4. Record review indicated the licensee failed to perform the minimum required frequency of evacuation fire drills. One drill record was provided for review. The record provided for review showed a July fire drill record noting for the first shift, but no documentation of the year. Survey staff explained to the LPN-C that evacuation drills must be performed twice per year per shift with at least one evacuation drill every other month frequency requirement. During the interview, LPN-C verified that the fire safety and evacuation plan for the home lacked these provisions. On April 11, 2023, at approximately 3:30 p.m., at the exit interview, the LPN-C acknowledged the above findings. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the	0 820		

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0 820	Continued From page 10 facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedroom # 6 with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident bedroom #6 on the lower-level floor. 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 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: On April 11, 2023, approximately from 1:20 p.m. to 2: 20 p.m., survey staff toured the home with the licensed practical nurse (LPN)-C. At approximately 1:50 p.m., survey staff observed several windows inside the lower-level resident bedroom #6 (occupied) and asked the LPN-C to open the egress window (encasement type with a handle) for measurement as the other three windows did not have handles to operate. Survey staff measured the clear window opening in bedroom #6 with a width dimension of 16 inches	0 820	Correction progress at Maplewood Care Residence 2338 Overlook Circle Maplewood, MN 55119 Fire Protection and physical environment 1 - New 23" window was installed pm on 4/11/2023. After installation completed 4/12/2023, when window was fully opened and measured egress clearance is just under 19". 2 - We are picking up another window this morning. If that does not work, we will special order a new window. 3 - Resident in room #6 will continue to be moved out of her room until window meeting required egress clearance is installed. 1 - Today,April 13, 2023 we purchased a second window. This window exceeds the requirements. 2 - Attached picture of window. 3 - Over 23 1/2" clearance opening	

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0 820	Continued From page 11 and a height of 37 inches. Survey staff explained to the LPN-C that the window with a clear opening of 16 inches does not meet the minimum state standard width of 20 inches for the egress window due to the obstruction of the window once the egress window is in the opened position. The LPN-C visually verified the finding and agreed that all other windows (no handles) in bedroom #6 are all the same dimensions. Survey staff further explained that the existing bedroom egress windows must meet the minimum net clear window opening width of 20 inches (and minimum height of 32.5 inches) with a clear minimum opening area of 4.5quare feet (648 square inches). On April 11, 2023, at approximately 3:20 p.m., at the exit interview, survey staff explained to the LPN-C that an immediate correction order was issued for the above finding in bedroom # 6. The LPN-C acknowledged the above finding and stated that she will coordinate with the licensed assisted living director-A for a plan of corrections to lift the immediate order. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate.	0 820	3 - Contractor is currently installing the window. 4 - Window installation will be completed today. Thank you for your assistance, -- Sandee Horton, LALD Director of Operations and Human Resources Parkinson's Specialty Care Residential Assisted Living phone: 763.550.1774 cell: 612.599.6581 fax: 612.437.4742	
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. (b) In the event of an emergency relocation, the	01060		

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	25791	A. BUILDING: _____ B. WING _____	04/13/2023

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01060	Continued From page 12 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 licensee failed to provide a written notice with the	01060		

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01060	Continued From page 13 required content for an emergency relocation to the resident or the resident's designated representative for one of one resident (R5). 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: R5's diagnosis included Parkinson's (disorder of the central nervous system). R5's service plan dated March 9, 2023, indicated R5 received services to include medication administration. A nursing note dated April 2, 2023, at 10:36 a.m., indicated R5 had been sent to the hospital with an increased heart rate. A nursing note dated April 5, 2023, at 12:49 p.m., indicated R5 would be discharged to a transitional care unit the following day. R5's record lacked evidence the following required content was provided to R5 or R5's designated representative: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and	01060		

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01060	Continued From page 14 Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and -a statement that, if the facility refused to provide housing or services after a relocation, the resident had 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. On April 12, 2023, during a telephone interview at 10:00 a.m., R5's designated representative stated they had not received a written emergency relocation notice. On April 13, 2023, during the exit conference at 5:30 p.m., registered nurse (RN)-F stated the licensee did not provide an emergency relocation notice to R5, or R5's designated representative. The licensee's undated contract termination policy indicated a written notice with the required content would be provided to the resident and designated representative in the case of an emergency relocation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident	01620		

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01620	Continued From page 15 reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted a comprehensive reassessment after a change of condition for two of two residents (R4, R5). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include:	01620		

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01620	Continued From page 16 R4 and R5's record lacked monitoring and reassessment by the RN with a hospital return and change in condition. R4 R4's diagnosis included Parkinson's (disorder of the central nervous system). R4's service plan dated August 1, 2021, indicated R4 received services to include medication administration, toileting, and activities of daily living. On April 13, 2023, at 12:15 p.m., unlicensed personnel (ULP)-D was observed to assist R4 to a table for lunch. A review of R4's record indicated: -December 2, 2022, R4 had a documented fall due to being "weak as she was ambulating from bathroom to her room." Actions taken were to take vital signs and assist to feet after resting. Record indicated the fall report was reviewed by licensed practical nurse (LPN)-C on December 2, 2022, but lacked evidence of RN assessment of the fall and for change of condition. -December 14, 2022, R4 had a documented unwitnessed fall due to "lost balance." Action taken was to remind to call for assistance and perform hourly safety checks. Record indicated the fall report was reviewed by registered nurse (RN)-F on December 15, 2022, but R4's record lacked documented evidence of RN assessment of the fall for change of condition. -a December 27, 2022, nursing note entered by licensed practical nurse (LPN)-C at 12:24 p.m., indicated R4 had an unresponsive episode followed by mumbling and garbled speech. Nursing note further indicated R4 was sent to the emergency department. The nurses notes lacked	01620		

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01620	Continued From page 17 documented evidence RN was notified of unresponsive episode or transport to the emergency department. A nursing note entered by LPN-C at 7:29 p.m., indicated R4 was hospitalized for a urinary tract infection. -a December 30, 2023, nursing note entered by LPN-C at 2:49 p.m., indicated R4 returned to the licensee's assisted living facility and was "fatigued." Nursing note further indicated lab work had been drawn due to functional decline and generalized weakness, but was still pending. The nurses notes lacked documented evidence RN was notified of R4's return to the facility or assessment, such as for change of condition upon return to the facility. -A comprehensive nursing assessment was completed by RN-F on January 12, 2023, twelve days after return from hospital. -January 23, 2023, R4 had a documented unwitnessed fall. Report indicated R4 self-transferred to a mat on the floor. Intervention was to assist back to recliner then back to mat on floor. Record indicated the fall report was reviewed by LPN-C on January 24, 2023. The record lacked evidence of RN assessment of the fall, for condition change. -A March 18, 2023, nursing note entered by LPN-J at 1:56 p.m., indicated R4 was re-hospitalized for an unresponsive episode. - A March 20, 2023, note entered by licensed assisted living director at 12:09 p.m., indicated R4 was to return to the licensee's assisted living between 2:00 p.m. and 2:30 p.m. The record lacked documented evidence RN was notified of R4's return to the facility or RN assessment for condition change. -March 23, 2023, R4 had a documented unwitnessed fall. Report indicated R4 self-transferred from bed. Intervention was to remind to call for assistance. The record	01620		

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01620	Continued From page 18 indicated the fall report was reviewed by LPN-C on January 24, 2023, but lacked evidence of RN assessment of condition change. -April 4, 2023, R4 had a documented witnessed fall. Report indicated R4 became agitated and slid to the floor while trying to ambulate. Intervention was to encourage to let staff assist with transfers. The record indicated the fall report was reviewed by LPN-C on April 5, 2023, but lacked documented evidence of RN assessment for condition change. - A comprehensive nursing assessment was completed by RN-F on April 6, 2023, 16 days after return from hospital. R5 R5's diagnosis included Parkinson's. R5's service plan dated March 9, 2023, indicated R5 received services to include medication administration, toileting, and activities of daily living. On April 13, 2023, R5 was noted to be in a transitional care unit. On March 26, 2023: A fall report, dated March 26, 2023 and completed by ULP-I indicated: -5:00 a.m. resident was found on the floor by ULP-I. ULP-I "got her up, checked her vitals, and informed her it was not time for breakfast." The report lacked evidence that 911 was called at the time of the fall and lacked documentation of RN notification or assessment. - time undocumented, licensed practical nurse (LPN)-C was left a voice message regarding fall. -8:00 a.m."immediate actions taken" listed in the fall report indicated the resident was sent to the emergency department. The nurses notes lacked	01620		

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01620	Continued From page 19 documentation that staff were directed by the RN to send R5 to the emergency department at 8:00 a.m. -8:24 a.m. the medical prescriber was notified of the fall. -3:34 p.m. a nurses note entered by LPN-J indicated R5 was sent to the hospital with signs of "syncope" (fainting) and staff reported R5 had two falls that morning. The note further indicated R5 "continued to appear unsteady when walking." There was no indication an additional fall report was completed following the second fall or that the RN was notified R5 was unsteady when walking. -3:34 p.m. nursing note entered by LPN-J, indicated R5 was admitted to the hospital with a fractured pelvis and vertebrae. The fall report was reviewed by LPN-C on April 5, 2023, ten days following the incident. R5's record lacked documentation the fall report was reviewed by the RN. On March 29, 2023, a nursing note entered by LPN-C at 2:20 p.m., indicated R5 returned to the licensee's assisted living facility after a two-day hospitalization, and further indicated resident would be able to ambulate with assistance of two staff. R5's record lacked evidence that a comprehensive nursing assessment was completed by an RN upon return from the hospital. R5 was readmitted to the hospital on April 2, 2023, for an increased heart rate. On April 5, 2023, at 12:49 p.m., a nursing note entered by LPN-C indicated R5 would be going to a transitional care unit on April 6, 2023.	01620		

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01620	Continued From page 20 On April 13, 2023, during an interview at 9:15 a.m., RN-F stated they were notified by staff via phone or messaging system when a resident had a fall. RN-F stated there was nothing documented that showed RN did a follow-up assessment in the residents' records. During a telephone interview on April 13, 2023, at 3:45 p.m., clinical nurse supervisor (CNS)-B indicated a change of condition assessment should have been completed by RN within twenty-four hours after a hospital return. CNS-B confirmed timely comprehensive nursing assessments for change in condition had not been completed for R4 or R5 following return to the facility after hospitalizations. The licensee's INITIAL AND ON-GOING NURSING ASSESSMENT OF RESIDENTS policy dated July 29,2021, indicated the RN will reassess the resident if the resident has a change in condition. The licensee's reporting, documenting and reviewing incidents policy revised December 14, 2022, indicated RN would complete an assessment of the resident following an incident, such as a fall. The policy further directed RN would document in the resident's record, the details of the incident and their assessment including the follow-up actions that were taken. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01760	Continued From page 21	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered per prescriber orders 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included cerebral infarction (stroke).	01760		

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01760	Continued From page 22 R1's service plan dated August 1, 2021, indicated R1 received services to include medication management and catheter care. R1's medication administration record (MAR) for April 2023, indicated R1 received renacidin (urinary tract infection preventative) 60 cubic centimeters (cc), instilled into bladder via catheter daily. R1's MAR instructions for administering medication included, but were not limited to the following: -clean end of catheter tubing with alcohol and insert medication tip into tubing and squeeze all medication into catheter -immediately kink catheter tubing to hold medication in -clean end of clear tubing cone with alcohol prep, reinsert into catheter tip, then let go of handheld kinked tubing On April 11, 2023, at 9:30 a.m., unlicensed personnel (ULP)-G explained their process for catheter medication administration. ULP-G stated they were to pour medication into a container, draw medication up into a catheter syringe, then insert medication into catheter. -ULP-G was observed to gather a graduated container, catheter syringe, and prepared to put medication into the graduated container. Surveyor clarified administration instructions. ULP-G further explained they followed their process because it was easier. ULP-G then followed instructions listed in MAR, but did not kink catheter tubing to hold medication in. On April 12, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated all ULP staff were expected to follow written instructions for all tasks	01760		

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01760	Continued From page 23 and to contact the nurse if there were any questions. CNS-B further stated staff were competency tested on required tasks. A Delegated Nursing Skills Training Form signed by registered nurse (RN)-F on March 2, 2023, indicated ULP-G was competency tested on administering catheter medication renacidin. The licensee's ADMINISTRATION OF MEDICATION, TREATMENT AND THERAPY BY UNLICENSED PERSONNEL policy dated July 29, 2021, indicated ULP who had been determined competent to follow procedures, may administer medications by following RN's written instructions. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in	01910		

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01910	Continued From page 24 the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to dispose of expired medications for two of two residents (R1,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 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: On April 12, 2023, at 11:30 a.m., during an observation of residents refrigerated medication storage with licensed practical nurse (LPN)-C, the following was observed: R1 In R1's medication supply: -one Novolog FlexPen (diabetes) 100 units/milliliter (mL); expired on July 28, 2022. -two additional Novolog FlexPens (diabetes) 100 units/mL; both expired on January 28, 2023. R3 In R3's medication supply: -boostrix injectable (booster immunization against	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	25791	A. BUILDING: _____ B. WING _____	04/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE RESIDENCE	2338 OVERLOOK CIRCLE MAPLEWOOD, MN 55119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01910	Continued From page 25 tetanus, diphtheria and pertussis) 0.5 mL; expired on December 1, 2021. During observation, LPN-C removed expired medication and stated, "these should have been destroyed." On April 12, 2023, at 10:30 a.m., clinical nurse supervisor (CNS)-B stated expired medications should have been removed from the refrigerator and destroyed. The licensee's DISPOSITION OR DISPOSAL OF MEDICATON policy, revised November 27, 2022, indicated medications that have been unused or discontinued "will be treated as household waste and will be destroyed." No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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

Type: Full
Date: *04/10/23*
Time: 13:00:00
Report: 1005231070

Food and Beverage Establishment Inspection Report

Location:
Maplewood Care Residence
2338 Overlook Circle
Maplewood, MN55119
Ramsey County, 62

Establishment Info:
ID #: 0037882
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6125974903
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.

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

NO FOOD THERMOMETER ON SITE. DISCUSSED REQUIREMENTS FOR A FOOD TEMPERATURE MEASURING DEVICE.

Comply By: 04/17/23

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

THERE WAS PREVIOUSLY A CFPM ON STAFF, BUT THEY NO LONGER WORK AT THE FACILITY. ANOTHER STAFF MEMBER WILL BE TAKING FOOD SAFETY TRAINING TO BECOME THE MN CFPM. FACT SHEET LEFT ON SITE.

Comply By: 05/10/23

Surface and Equipment Sanitizers

Utensil Surface Temp.: = at 160+ Degrees Fahrenheit
Location: DISH WASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 40 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Food and Beverage Establishment Inspection Report

Process/Item: Cold Hold/CHEESE
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CHICKEN BREAST
Temperature: 37 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/MILK
Temperature: 41 Degrees Fahrenheit - Location: BASEMENT REFRIGERATOR
Violation Issued: No

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

INSPECTION COMPLETED WITH CNA AND DIRECTOR, AND REVIEWED WITH HRD NURSE EVALUATOR, TAMMY CARLSON.

DISCUSSED EMPLOYEE ILLNESS, HANDWASHING, BARE HAND CONTACT AND GLOVE USE, FOOD TEMPERATURES, AND DATE MARKING.

FACILITY REGULARLY USES TEMPERATURE STRIPS TO VERIFY THAT THE DISHWASHER IS SANITIZING. AFTER INSPECTION, OPERATOR RAN THE DISHWASHER AND SENT INSPECTOR A PICTURE OF THE TEMPERATURE STRIP, SHOWING IT REACHED AT LEAST 160 DEGREES F.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND THE CEILING HAS A TEXTURED, POPCORN FINISH. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

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 1005231070 of 04/10/23.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: __/__/____

Signed:_____
ELIZABETH ROHLIK
CNA

Signed:_____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us