Electronically Delivered

August 2, 2022

Administrator
Silver Maple Residence, Inc.
710 28th Street Southeast
Brainerd, MN 56401

RE: Project Number(s) SL21680015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 7, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The correction order documentation should include the following:

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

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

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

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

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

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

Sincerely,

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21680	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	710 28TH STREET SE BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders have been issued pursuant to a survey. Determination of whether a violation has been 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: SL#21680015 On July 5, 2022, through July 7, 2022, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider, and the following correction orders were issued. At the time of the survey, there were nineteen (19) residents that were 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 Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470		

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0 470	Continued From page 1 (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a staffing plan to determine staffing levels to meet the needs of all residents and to ensure the plan was implemented and posted as required. This had the potential to affect all nineteen (19) residents, staff and visitors. This practice resulted in a level two violation (a	0 470		

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0 470	Continued From page 2 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: The licensee held an assisted living facility license and was licensed for a capacity of twenty-eight (28) residents, with a current census of nineteen (19) residents. During the facility tour on July 5, 2022, at approximately 11:05 a.m., with licensed assisted living director (LALD)-A, the surveyor observed the lack of a posted staffing plan. The surveyor asked LALD-A if a staffing plan had been developed and posted. LALD-A stated, "no, we have this" and pointed to a schedule that indicated who the staff were for the day and stated, "this rarely changes." On July 5, 2022, at approximately 11:10 a.m., LALD-A confirmed there was no staffing plan or matrix used by licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 3 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a written emergency preparedness plan with all the required content and post an emergency preparedness plan prominently. This had the potential to affect all nineteen (19) residents receiving services under the assisted living license. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 680		

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0 680	Continued From page 4 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: During the entrance conference on July 5, 2022, at approximately 10:20 a.m., the surveyor requested to review the licensee's emergency preparedness plan. On July 5, 2022, at approximately 2:00 p.m., licensed assisted living director (LALD)-A provided a binder titled Emergency Plan. The binder included licensee's emergency preparedness and disaster plan, however, lacked the following required content: - a description of the population served by the licensee; - procedure for tracking staff and residents; - development of policies/procedures to address: - an evacuation plan customized for the facility; - shelter in place; - a tracking system used to document locations or residents and staff; - the medical record documentation system to preserve resident information. - a communication plan that addressed: - arrangements with other facilities; - names and contact information for staff, resident physicians, and other facilities; - contact information for federal, state, tribal, local EP staff, and ombudsman; - a method of sharing resident information and medical documentation; - a means to provide information regarding	0 680		

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0 680	Continued From page 5 the facility's needs, and its ability to provide assistance, including occupancy information; and -a method of sharing information from the licensee's emergency plan with residents and their families. - EP training program for staff (including documentation of training provided); and - EP testing/annual testing requirements. On July 5, 2022, at approximately 10:45 a.m., during a facility tour with LALD-A, the surveyor observed no signage or information posted in the main entrance or elsewhere in the facility regarding the licensee's emergency plan. On July 5, 2022, at approximately 2:30 p.m., clinical nurse supervisor (CNS)-B confirmed licensee's emergency preparedness plan was not posted as required and lacked required information. The surveyor asked CNS-B if licensee's staff had been working on completing the emergency preparedness plan/program requirements, CNS-B stated, "yes, we've been working on it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code:	0 780		

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0 780	Continued From page 6 (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain functioning smoke alarms within the facility as required. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On July 06, 2022, at approximately 11:15 am, while touring with the Administrator, it was	0 780		

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0 780	Continued From page 7 observed that multiple smoke alarms installed within facility were not functioning properly. There were 1 of 4 resident rooms within the facility that had a smoke alarm that did not have the battery installed in the device. Additionally, the smoke alarm/Carbon monoxide combination alarm located in the living room / common space within the facility had been taken down and not replaced. The administrator verbally confirmed survey staff observations during the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 8 (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 observation, interview and record review, the licensee failed to provide the required fire safety training and evacuation plans for residents and staff. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 06, 2022, at approximately 10:15 am, survey staff asked to review the facility ' s fire safety and evacuation documentation. The following item were noted: 1. EVACUATION DRILLS	0 810		

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0 810	Continued From page 9 The facility's documented drill record indicated licensee failed to show compliance with the minimum number of required employee fire and evacuation drills performed to date for a minimum of two drills per year per shift with at least one drill every other month for a total minimum of six evacuation drills per year. The fire drills that were conducted over the last 12 months consisted of one drill completed in June for the evening shift, three fire drills completed in May for the evening, day, and overnight shifts, and one fire drill in March for the day shift. The facility failed to conduct fire and evacuation drill for the overnight shift and did not complete the fire drills on an every other month basis. Survey staff explained the dates for their employee drills were not in compliance with the minimum of every other month and that the facility did not conduct two fire and evacuation drills for the overnight shift within the last 12 months. 2. TRAINING The facility's training documentation lacked a policy for the training of residents that can self-assist in their evacuation in the event of an emergency. The facility was also not able to provide any records for resident fire evacuation covering the proper actions to be taken by the residents in the event of a fire to include their movement, evacuation, or relocation, which is required annually. Survey staff explained that if the residents are evaluated as a self-assist in the event of an emergency that they also are required to be trained annually to ensure that all self-assist residents know what to do and where to go in the event of an emergency. The administrator verbally confirmed survey staff	0 810		

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0 810	Continued From page 10 observations during record review. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	0 810		
0 930 SS=C	144G.50 Subd. 2 (d-e; 1-4) Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included all required content for two of two residents (R1, R2) with records reviewed. This had the potential to affect all nineteen (19)	0 930		

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0 930	Continued From page 11 residents who received assisted living services. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1's service plan dated August 1, 2021, indicated R1 received services to include medication administration, supervision for dressing, grooming, bathing, behavior monitoring and treatment management services. R2's service plan dated August 1, 2021, indicated R2 received services to include medication administration, supervision for glucose (sugar) checks, behavior management and treatment management services. R1 and R2's [name of facility] Resident Assisted Living Contract dated August 1, 2021, lacked the following content: - the right under section 144G.54 to appeal the termination of an assisted living contract; - the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent was required for a transfer; and - contact information for the Ombudsman for Mental Health and Developmental Disabilities. On July 6, 2022, at 10:30 a.m., clinical nurse supervisor (CNS)-B confirmed the same assisted	0 930		

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	21680	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	710 28TH STREET SE BRAINERD, MN 56401

(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
0 930	Continued From page 12 living contract was used for all residents and was missing the required content as identified above. Additionally, CNS-B stated, "honestly, some of the things we haven't gotten to yet." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 930		
0 940 SS=C	144G.50 Subd. 2 (e; 5-7) Contract information (5) a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (i) whether the facility is enrolled with the commissioner of human services to provide customized living services under medical assistance waivers; (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (iv) whether the facility requires a resident to pay privately for a period of time prior to accepting payment under medical assistance waivers or the housing support program, and if so, the length of time that private payment is required; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and	0 940		

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0 940	Continued From page 13 (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program; (6) the contact information to obtain long-term care consulting services under section 256B.0911; and (7) the toll-free phone number for the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 5, 2022, at 10:30 a.m., during the entrance conference, the surveyor requested a copy of the licensee's assisted living contract provided to residents from clinical nurse supervisor (CNS)-B. R1 R1's [name of facility] Resident Assisted Living Contract indicated R1 started assisted living services August 1, 2021. R1's service plan dated August 1, 2021, indicated	0 940		

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0 940	Continued From page 14 R1 received services to include medication administration, supervision for dressing, grooming, bathing, behavior monitoring and treatment management services. R2 R2's [name of facility] Resident Assisted Living Contract indicated R2 started assisted living services July 26, 2021. R2's service plan dated August 1, 2021, indicated R2 received services to include medication administration, supervision for glucose (sugar) checks, behavior management and treatment management services. R1 and R2's assisted living contract did not include the following required content: -a description of the facility's policies related to medical assistance waivers under chapter 256S and section 256B.49 and the housing support program under chapter 256I, including: (ii) whether the facility has an agreement to provide housing support under section 256I.04, subdivision 2, paragraph (b); (iii) whether there is a limit on the number of people residing at the facility who can receive customized living services or participate in the housing support program at any point in time. If so, the limit must be provided; (v) a statement that medical assistance waivers provide payment for services, but do not cover the cost of rent; (vi) a statement that residents may be eligible for assistance with rent through the housing support program; and (vii) a description of the rent requirements for people who are eligible for medical assistance waivers but who are not eligible for assistance through the housing support program.	0 940		

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0 940	Continued From page 15 On July 6, 2022, at 10:30 a.m., CNS-B confirmed the same assisted living contract was used for all residents and was missing the required content as identified above. Additionally, CNS-B stated, "honestly, some of the things we haven't gotten to yet." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 940		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and	01650		

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01650	Continued From page 16 (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: R1 R1's diagnoses included schizophrenia. R1's service plan dated August 1, 2021, indicated R1 received services to include medication administration, supervision for dressing, grooming, bathing, behavior monitoring and treatment management services. R1's service plan lacked the following required content: - a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current	01650		

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01650	Continued From page 17	01650		

assessment and resident preferences;
- the schedule and methods of monitoring assessments of the resident; and
- the schedule and methods of monitoring staff providing services.

R1's Treatment and Medication log sheet dated June 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff :
- bathing three times weekly;
- haircare reminder daily;
- oral care supervision and reminder twice daily;
- dressing supervision and reminders;
- accuchecks (blood sugar checks) twice daily;
- monitor for depression every shift;
- meal and snack reminders twice daily;
- behavior management every shift;
- monitor for alcohol/drug abuse every shift;
- medication administration twice daily;
- daily supervision;
- nightly supervision hourly checks;
- vitals monthly; and
- mental health coordination as needed (PRN).

R2
R2's diagnoses included schizophrenia.

R2's service plan dated August 1, 2021, indicated R2 received services to include medication administration, supervision for glucose (sugar) checks, behavior management and treatment management services.

R2's service plan lacked the following required content:
- a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;

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01650	Continued From page 18 - the schedule and methods of monitoring assessments of the resident; and - the schedule and methods of monitoring staff providing services. R2's Treatment and Medication log sheet dated June 2022, included the following completed services signed off by unlicensed personnel and licensed nursing staff: - supervision/reminders for bathing, dressing, shaving daily; - accuchecks three times a day, three times a week; - behavior management every shift; - training in independent living services twice weekly and PRN; - room checks every Monday; - monitor for alcohol/drug use every shift; - meal and snack supervision/reminders twice daily; - medication administration twice daily; - daily supervision; - nightly supervision with hourly checks; - monthly vitals; and - mental health coordination PRN. On July 6, 2022, at approximately 2:40 p.m., clinical nurse supervisor (CNS)-B confirmed the service plan did not list the tasks being performed for managing and monitoring R1 and R2's individual needs, lacked the method of monitoring unlicensed personnel and lacked inclusion of an assessment with a change of condition by the registered nurse (RN). The licensee's Contents of Service Plans dated January 2017 indicated a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment, the schedule and	01650		

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01650	Continued From page 19 methods of monitoring reviews and re-assessments of the resident would be included in the resident's service plan. Additionally, the policy indicated the service plan would include all required information and would be signed by the RN No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01730 SS=E	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	01730		

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01730	Continued From page 20 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for two of two residents (R1, R2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include:	01730		

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01730	Continued From page 21 During the entrance conference on July 5, 2022, at approximately 10:20 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided medication management services to the residents in the facility. R1 R1's diagnoses included schizophrenia and diabetes. R1's service plan dated August 1, 2021, indicated R1 received services to include medication administration. R1's Medication Sheet dated June 2022 included: one blood pressure reducer, two vitamin supplements, one heart rate stabilizer, one antipsychotic, one antiallergy, one diabetic management medication, one cholesterol reducer, one blood thinner and two diabetic managing injectables. On July 6, 2022, at approximately 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R1's morning medications. R1's medication management record did not include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of medication management tasks that may be delegated to unlicensed personnel; - documentation of specific resident instructions relating to the administration of medications; and - the medication management record must be current and updated when there are any changes. R2	01730		

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01730	Continued From page 22 R2's diagnoses included schizophrenia and diabetes. R2's Service Plan dated August 1, 2021, indicated R2 received services to include medication administration. R2's Medication Sheet dated June 2022 included: one mild pain reliever, one mood stabilizer, two diabetic medications, one anti-psychotic, one anti-anxiety, one prostrate medication, one stomach acid reducer, one blood pressure reducer, two vitamin supplements and one insulin injectable medication. On July 6, 2022, at approximately 8:23 a.m., the surveyor observed ULP-D administer R2's morning medications. R2's medication management record did not include the following: - a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - identification of medication management tasks that may be delegated to unlicensed personnel; - documentation of specific resident instructions relating to the administration of medications; and - the medication management record must be current and updated when there are any changes. On July 7, 2022, at approximately 10:00 a.m., CNS-B confirmed R1 and R2's individualized medication management record lacked all required content noted above. The licensee's policy Development of the Individualized Medication Management Plan and Individualize Medication Administration Record	01730		

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01730	Continued From page 23 dated January 2017 indicated an individualized medication management plan would be developed for each resident and would be a part of the service plan. Additionally, the policy indicated after the registered nurse (RN) has developed the individual medication management plan, the RN would develop a medication administration record with detailed information about the medications staff would be managing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure prescription medications were stored in a secured manner allowing only authorized personnel access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	01880		

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01880	Continued From page 24 The findings include: On July 5, 2022, at approximately 11:18 a.m., in the presence of licensed practical nurse (LPN)-C, the surveyor observed a medication refrigerator sitting inside the kitchen/nurse work area. The medication refrigerator lacked a lock to secure medications. The medication refrigerator contained a supply of 3 single dose insulin pens belonging to R2 and one multidose insulin pen belonging to R1 as follows: - one opened box of 3 Ozempic 0.5 milligram (mg) insulin pens; and - one single insulin pen Bydureon Bcise 2 mg of exenatide per 0.85 milliliters (mL) suspension. On July 5, 2022, at approximately 11:20 a.m., LPN-C confirmed the medication refrigerator contained unsecured medication and was kept in a common area accessible to all staff. The licensee's policy Storage of Medications dated January 2017, indicated the registered nurse (RN) would recommend where medications should be stored and when residents reside in a senior housing setting, the RN would develop a procedure to secure medications that are delivered to the building rather than directly to the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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01940	Continued From page 25	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen 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 management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (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. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop individual treatment management plans with all required content for one of two residents (R1) who	01940		

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SILVER MAPLE RESIDENCE INC	710 28TH STREET SE BRAINERD, MN 56401

(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
01940	Continued From page 26 received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 5, 2022, at approximately 10:30 a.m., clinical nurse supervisor (CNS)-B confirmed the licensee provided treatment and therapy services to residents. R1's diagnoses included schizophrenia and diabetes. R1's service plan dated August 1, 2021, indicated R1 received services to include medication administration, supervision for dressing, grooming, bathing, behavior monitoring and treatment management services. On July 6, 2022, at 8:27 a.m., the surveyor observed unlicensed personnel (ULP)-D provide R1 a plastic supply box that contained a glucometer case and diabetic testing supplies to check R1's glucose (sugar) level. R1 cleaned his hands, opened the case, assembled the lancet pen used for pricking his finger and placed the test strip into the glucometer. R1 proceeded with the testing process and received a glucose result of 111 milligrams per deciliter (mg/dl). ULP-D stated, "we monitor that he [R1] does it correctly	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21680	A. BUILDING: _____ B. WING _____	07/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SILVER MAPLE RESIDENCE INC	710 28TH STREET SE BRAINERD, MN 56401

(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
01940	Continued From page 27 and tells us the results." R1's record lacked an Individualized Treatment and Therapy plan to include the following : - documentation of specific resident instructions relating to the treatment or therapy administration; and - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On July 6, 2022, at approximately 2:30 p.m., CNS-B confirmed R1's Individualized Treatment and Therapy Plan lacked the above noted requirements. The licensee's Development of the Individualized Treatment and Therapy Management Plan and Individualized Treatment and Therapy Management Record policy dated January 2017 indicated the registered nurse (RN) would develop a treatment and therapy plan that would include the above noted requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *07/05/22*
Time: 12:00:00
Report: 1017221113

Food and Beverage Establishment Inspection Report

Location:
Silver Maple Residence, Inc.
710 S.E. 28th Street
Brainerd, MN56401
Crow Wing County, 18

Establishment Info:
ID #: 0014920
Risk: High
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Silver Maple Residence, Inc.

Phone #: 2188223067
ID #: 16758

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

No NEW orders were issued during this inspection.

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: MILK LOCATED IN COOLER 1
Violation Issued: No

Process/Item: Cold Holding
Temperature: 35 Degrees Fahrenheit - Location: CHEESE LOCATED IN COOLER 2
Violation Issued: No

Process/Item: Cold Holding
Temperature: 37 Degrees Fahrenheit - Location: LAZAGNA LOCATED IN COOLER 3
Violation Issued: No

Process/Item: Cooking
Temperature: 163 Degrees Fahrenheit - Location: PORK FROM PAN ON STOVE TOP
Violation Issued: No

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

DISCUSSION:

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, HAND WASHING, EMPLOYEE ILLNESS LOG.