DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic delivery

May 23, 2022

Administrator
Maple Hill Senior Living, LLC
3030 Southlawn Drive
Maplewood, MN 55109

RE: Initial License Number 403336
Health Facility Identification Number (HFID) 31968
Project Number(s) SL31968015

Dear Administrator:

On May 18, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your facility to determine correction of orders found on the initial evaluation completed December 17, 2021. The follow-up evaluation found the facility to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective May 18, 2022.

Effective, August 1, 2021 MDH is granting your ASSISTED LIVING DEMENTIA CAPACITY facility license. Your license will expire July 31, 2022. Your license number is 403336. You will not receive a replacement license certificate until your license is due to renew. If you have not received a letter from us with information regarding renewing your license within 45 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: Health.Homecare@state.mn.us.

Furthermore, the follow-up evaluation determined your facility had not corrected all of the state licensing orders issued pursuant to the December 17, 2021 initial evaluation.

0510-Infection Control Program-144g.41 Subd. 3 = $500.00

The details of the violations noted at the time of this follow-up evaluation completed on May 18, 2022 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

Also, at the time of this follow-up evaluation completed on May 18, 2022, we identified the following violation(s):

0660-Tuberculosis Prevention And Control-144g.42 Subd. 9
1540-Training In Dementia Care Required-144g.64 (a)

The details of the violation(s) noted at the time of this follow-up evaluation are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), by the correction order date, the licensee must document in the provider's records any action taken to comply with the correction order by the correction order date. The commissioner may request a copy of this documentation and the assisted living facility's action to respond to the correction orders in future evaluations, upon a complaint investigation, and as otherwise needed.

IMPOSITION OF FINES:
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.

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

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

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

Health.HRD.Appeals@state.mn.us.

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

We urge you to review these orders carefully. If you have questions, please contact Jess Gallmeier at 651-247-0268.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Jess Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-247-0268 Fax: 651-215-9697

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	R 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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 this correction order(s) has 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: Project # SL31968015-1 On May 16, 2022, through May 18, 2022, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on December 17, 2021. At the time of the survey, there were 66 residents receiving services under the Assisted Living with Dementia Care license. As a result of the revisit, the following orders were reissued.	{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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	{0 480}		

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{0 480}	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: No futher action required.	{0 480}		
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	{0 510}		

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{0 510}	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards related to COVID-19. In addition, the licensee failed to ensure appropriate infection control practices were implemented during personal cares and delegated treatments/therapies for one of one resident (R4), and the licensee failed to ensure infection control practices were maintained during meal service in the dining area and for residents receiving room service. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: COVID-19 On May 16, 2022, at approximately 9:20 a.m., the surveyor observed a guest arrive at the licensee's reception area and walk towards and into the dementia unit without being screened for COVID-19 signs and symptoms and have their temperature recorded. On May 16, 2022, at approximately 10:15 a.m., licensed assisted living director (LALD)-CEO acknowledged the surveyor's observation and stated the licensee did not have someone to	{0 510}		

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{0 510}	Continued From page 3	{0 510}		

monitor the reception area and direct visitors to complete the COVID-19 signs and symptoms screening. LALD-CEO also stated the licensee was in the process of employing a receptionist.

The licensee's COVID-19 Monitoring Daily for COVID Symptoms - Oxygen and Temperature document dated May 1-May 16, 2022, indicated the following missed COVID-19 screening to include temperature on various days:
- R9 on May 6, 11, and 12
- R11 on May 2, 6, 7, 8, and 14, 2022

On May 16, 2022, at approximately 2:20 p.m., director of nursing (DON)-P acknowledged the residents' records were missing screening in various dates and stated the licensee had noted a trend in one employee who will need to be retrained.

The Centers for Disease Control and Prevention (CDC) guidance, dated September 10, 2021, included recommendations to monitor residents daily for COVID-19, including temperature, symptoms consistent with COVID-19, and assessment of oxygen saturation.

The CDC guidance, dated February 2, 2022, indicated licensees must establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following three criteria so that they can be properly managed:
1) a positive viral test for SARS-CoV-2,
2) symptoms of COVID-19, or
3) close contact with someone with SARS-CoV-2 infection (for patients and visitors).

The licensee's Infection Control COVID-19 policy dated February 11, 2022, indicated the licensee is

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{0 510}	Continued From page 4 following the guidelines put forth by the Minnesota Department of Health and the CDC. DELEGATED TASKS - PERSONAL CARES On May 17, 2022, at approximately 2:30 p.m., unlicensed personnel (ULP)-D emptied R4's Purewick (external female catheter) canister content. ULP-D did not put on gloves before emptying the canister content. R4's Service Plan dated April 22, 2022, indicated R4 received assistance with shower, TED (compression and antiembolism) stocking assist, grooming, assessments, vital signs, bed making, housekeeping, laundry, medication management, safety checks, catheter care, toileting, blood glucose monitoring, weight check, wound monitoring and escort. R4's Treatment/Therapy Management Plan dated April 19, 2022, indicated R4 received blood glucose monitoring, compression garments assist and Purewick assist. On May 17, 2022, at approximately 2:30 p.m., registered nurse (RN)-R, who was with the surveyor during the observation, acknowledged ULP-D did not follow infection control procedures. The licensee's Infection Control policy dated February 11, 2022, indicated gloves are worn whenever there may be direct contact between employee hands and blood, body fluids, secretions, feces, or contaminated item, such as soiled linens or wound dressings. MEAL SERVICE On May 16, 2022, at approximately 12:20 p.m., unlicensed personnel (ULP)-S served residents in the dementia unit dining area. ULP-S started	{0 510}		

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{0 510}	Continued From page 5 delivering food to the residents at their tables before washing hands. On May 16, at approximately 12:50 p.m., ULP-S arranged served food, drinks, and a dessert (angel food cake) into a three shelved cart for room service. The bottom shelf was carrying the dessert, which was not covered to protect from any splash, germs, or contamination. On May 16, 2022, at approximately 1:10 p.m., RN-P acknowledged the dessert was not covered, and stated it was necessary to cover it to prevent any germs or contamination on the cakes. The licensee's Hand Washing policy dated February 11, 2022, indicated proper hand washing should be used to protect the spread of infections. The policy lacked verbiage to include room service delivery procedures. No further information was provided.	{0 510}		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide	0 660		

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0 660	Continued From page 6 technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the license failed to maintain a tuberculosis (TB) infection control program based on guidelines by the Center for Disease Control (CDC) and Minnesota Department of Health and ensure the TB infection control program covered all paid and unpaid employees for one of one employee (unlicensed personnel (ULP)-Q) with employee record reviewed. 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 was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On May 16, 2022, at approximately 12:20 p.m., ULP-Q served lunch to the residents in the dementia unit. ULP-Q started employment with licensee on April 19, 2022. ULP-Q's record included a Mantoux tuberculin skin test (baseline screening) dated April 4, 2022, and results read on April 6, 2022. ULP-Q's record lacked a second test for Mantoux tuberculin skin	0 660		

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0 660	Continued From page 7 test. ULP-Q's record also lacked Tuberculosis (TB) history and symptom screen completed at time of hire. On May 17, 2022, at approximately 1:35 p.m., director of nursing (DON)-P acknowledged ULP-Q's record was missing the required content and stated the licensee had introduced a new system to check off new employee records to ensure none was missed during hiring process. The licensee's Employee Records policy dated February 11, 2022, indicated new staff will be screened for active TB using the baseline TB screening tool and have a two step Mantoux conducted with results documented. In addition, individuals providing assisted living services require verification health screenings for TB have taken place and the dates of those screenings should be included in the employee records. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	0 660		
{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,	{0 810}		

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{0 810}	Continued From page 8 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: No futher action required.	{0 810}		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to	01540		

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01540	Continued From page 9	01540		

dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter;

This MN Requirement is not met as evidenced by:
Based on observation, interview and record review, the licensee failed to ensure one of one employee (unlicensed personal (ULP)-Q) received the required amount of dementia care training in the required time frame.

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:

On May 16, 2022, at approximately 12:25 p.m., ULP-Q served lunch to residents in the dementia care unit.

ULP-Q started employment with licensee on April 19, 2022.

ULP-Q's employee record included dementia care training in the topics: activities, communication, overview, problem solving, and the face of dementia for a total of four and one

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01540	Continued From page 10 half (4.5) hours. ULP-Q's employee record lacked completion of at least eight hours of initial dementia training on topics specified within 80 working hours of the employment start date. On May 17, 2022, at approximately 2:45 p.m., director of nursing (DON)-P acknowledged ULP-Q's training record lacked the required hours of dementia care training and stated the licensee had discovered the anomaly and was already working with employees whose records were less than the required hours. No further information was provided.	01540		
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to dispose of expired medications and ensure medications had labels with legible information including the expiration or beyond-use date of a time-dated drug for two of two residents (R20, R21) 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	{01890}		

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{01890}	Continued From page 11 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 finding include: R20 On May 17, 2022, at approximately 12:20 p.m., the surveyor observed the contents of R20's medication box, which included undated and used Humalog mix 75/25 unit/ milliliter (ml) insulin pen. R20's box also included an unlabeled glucometer and unlabeled blood glucose test strips. R20 was admitted on February 23, 2022. R20's service plan dated April 13, 2022, indicated R20 was receiving the following services: cares, abuse prevention, shower, nail care by nurse, 90-day assessment, annual assessment, vital signs, weight, bed making, housekeeping, laundry, medication administration, transfer assist of one, safety check, and toileting. R20's signed provider orders dated April 19, 2022, indicated R20 received the following: -amlodipine tablet 2.5 milligram (mg) by mouth daily -atorvastatin tablet 40 mg by mouth daily -blood sugar checks daily -Easy Touch lancets test blood glucose daily -Eliquis tablet 5 mg by mouth daily -escitalopram tablet 5 mg take one half tablet (2.5 mg) by mouth daily -pantoprazole tablet 20 mg by mouth daily, and -quetiapine tablet 25 mg take one half tablet by mouth every night at bedtime.	{01890}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	R 05/18/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{01890}	Continued From page 12 On May 17, 2022, at approximately 12:40 p.m., registered nurse (RN)-R acknowledged R20's box had an undated insulin pen and unlabeled blood glucose supplies. In addition, RN-R stated the medication cart is checked weekly to ensure its safety and compliance. R21 On May 17, 2022, at approximately 12:40 p.m., the surveyor observed the contents of R21's medication box included the following expired medications: -acetaminophen tablets 325 mg expired on March 20, 2022 -acetaminophen tablets 325 mg expired on March 31, 2022 R21 was admitted on February 3, 2020, under the comprehensive license and transitioned to receive services under the assisted living licensure on August 1, 2021. R21's service plan dated August 3, 2021, indicated R20 received the following services: abuse prevention, cares, bathing, vital signs, housekeeping, 90-day assessment, laundry and linen change, medication assistance, safety checks, and escort. R21's signed provider orders dated January 18, 2022, indicated R20 received the following: -atorvastatin tablet 10 mg by mouth every night -calcium/D3 600 mg - 800 unit by mouth daily -divalproex tablet 500 mg by mouth twice daily -duloxetine capsule 30 mg by mouth once daily -gabapentin capsule 300 mg by mouth twice daily -hydrochlorothiazide tablet 25 mg take one half tablet by mouth daily -melatonin tablet 3 mg by mouth at bedtime daily	{01890}		

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{01890}	Continued From page 13 -losartan potassium tablet 100 mg by mouth daily -labetalol tablet 200 mg twice daily by mouth, and -acetaminophen tablet 325 mg by mouth every four hours as needed. On May 17, 2022, at approximately 1:10 p.m., RN-R acknowledged R21's medication box had expired medications. RN-R also stated the medication cart is checked weekly to ensure its safety and compliance. The licensee's Medications Storage policy dated February 11, 2022, indicated the licensee will keep medications secure and stored per manufacturer's direction. The policy lacked the verbiage to include labeling and expired medications. No further information was provided.	{01890}		
{02040} SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: No futher action required.	{02040}		

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Electronically Delivered

February 3, 2022

Administrator
Maple Hill Senior Living, LLC
3030 Southlawn Drive
Maplewood, MN 55109

RE: Project Number(s) SL31968015, HL31968006C and HL31968008C

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 17, 2021, 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.

In addition, on December 8, 2021, the Minnesota Department of Health, State Rapid Response team conducted an investigation of complaints HL31968006C and HL31968008C.

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

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

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

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00

St - 0 - 0620 - 144g.42 Subd. 6 - Compliance With Requirements For Reporting Ma - $3,000.00

St - 0 - 1760 - 144g.71 Subd. 8 - Documentation Of Administration Of Medication - $3,000.00

St - 0 - 1950 - 144g.72 Subd. 4 - Administration Of Treatments And Therapy - $3,000.00

St - 0 - 2310 - 144g.91 Subd. 4 - Appropriate Care And Services - $3,000.00

The total amount you are assessed is $12,500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. 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 addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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

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

INFORMAL CONFERENCE
In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Maple Hill Senior Living, LLC. Please contact Jessica Gallmeier at 651-247-0268 on or before Wednesday, February 9, 2022, to schedule the conference call.

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,

Jessica Gallmeier, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jess.gallmeier@state.mn.us
Phone: 651-247-0268 Fax: 651-215-9697

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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0 000	Initial Comments Initial comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL# 31968015 On December 8, 2021, through December 17, 2021, the Minnesota Department of Health (MDH) conducted a survey at the above provider, and the following correction orders are issued. In addtion, on December 8, 2021, the following complaints were conducted: HL31968006C and HL31968008C. At the time of the survey, there were 72 residents receiving services under the provider's Assisted Living with Dementia Care 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 Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND	

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0 000	Continued From page 1	0 000	REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 250 SS=F	144G.20 Subdivision 1. Conditions (a) The commissioner may refuse to grant a provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection,	0 250		

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0 250	Continued From page 2 survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the management officials who were in charge of the day-to-day operations, and responsible for the resident's assisted living services, understood all of the assisted living facility with dementia care regulations. This has the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 250		

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0 250	Continued From page 3 The findings include: During the entrance conference on December 13, 2021, at approximately 11:00 a.m., executive director (ED)-P and registered nurse (RN)-A confirmed they were responsible for and participated in the day-to-day operations. ED-P and RN-A stated they were familiar with the Assisted Living with Dementia Care licensing rules. The licensee had attested they read and understood the Assisted Living with Dementia Care licensing statutes and rules upon application; however, the following orders were issued: Refer to licensing order at Statute 144G.41, Subd 1, (13), (i), (B). The licensee failed to ensure food was prepared and served according to the Minnesota Food Code. Refer to licensing order at Statute 144G.41, Subd 3. The licensee failed to establish and maintain an infection control program related to COVID-19 and failed to ensure appropriate infection control practices were implemented during personal cares and delegated treatments/therapies. Refer to licensing order at Statute 144G.42, Subd 6. The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment, and complete a thorough investigation. In addition, the licensee failed to implement written procedures pertaining to allegations of maltreatment. Refer to licensing order at Statute 144G.42, Subd 6. The licensee failed to develop and implement individual abuse prevention plans (IAPPs).	0 250		

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0 250	Continued From page 4 Refer to licensing order at Statute 144G.42, Subd 8. The licensee failed to ensure current employee records were maintained to include all required content. Refer to licensing order at Statute 144G.42, Subd 10. The licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. Refer to licensing order at Statute 144G.43, Subd 3. The licensee failed to ensure the resident record included documentation of complaints, including any resolution, and failed to ensure resident incidents, including actions taken in response to the needs of resident, were documented. Refer to licensing order at Statute 144G.45, Subd 2. The licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training on fire safety and evacuation to residents capable of self-evacuation; and failed to complete required employee evacuation drills. Refer to licensing order at Statute 144G.62, Subd 4. The licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee. Refer to licensing order at Statute 144G.70, Subd 1. The licensee failed to ensure staff were available sufficient in qualifications, competency, and numbers to adequately provide the services agreed to in the assisted living contract.	0 250		

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0 250	Continued From page 5 Refer to licensing order at Statute 144G.70, Subd 2. The licensee failed to ensure a registered nurse (RN) conducted resident reassessments and monitoring based on the needs of the residents. Refer to licensing order at Statute 144G.70, Subd 4. The licensee failed to ensure resident service plans were authenticated and services were provided as required by the service plan. Refer to licensing order at Statute 144G.70, Subd 4. The licensee failed to ensure the service plan included the required content. Refer to licensing order at Statute 144G.71, Subd 3. The licensee failed to ensure reassessment and monitoring of medication management services. Refer to licensing order at Statute 144G.71, Subd 7. The licensee failed to specify in writing, specific instructions for each resident and document those instructions in the resident record. Refer to licensing order at Statute 144G.71, Subd 8. The licensee failed to ensure medications were administered as prescribed by the physician. Refer to licensing order at Statute 144G.71, Subd 13. The licensee failed to ensure prescriber orders were obtained. Refer to licensing order at Statute 144G.71, Subd 20. The licensee failed to ensure medications were labeled when opened. Refer to licensing order at Statute 144G.72, Subd 3. The licensee failed to ensure individual treatment/therapy plans were developed.	0 250		

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0 250	Continued From page 6 Refer to licensing order at Statute 144G.72, Subd 4. The licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel (ULP) in the proper method to perform treatment/therapies, the ULPs demonstrated competency, and delegated treatment/therapy instructions were specified in writing. Refer to licensing order at Statute 144G.72, Subd 6. The licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy. Refer to licensing order at Statute 144G.81, Subd 1. The licensee failed to provide a hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. Refer to licensing order at Statute 144G.84. The licensee failed to ensure services were provided in a person-centered manner that promoted resident dignity. Refer to licensing order at Statute 144G.84. The licensee failed to ensure an individualized activity plan was developed. Refer to licensing order at Statute 144G.84. The licensee failed to ensure behavioral symptoms negatively impacting the resident were included in the service plan or care plan, and staff initiated and coordinated outside consultation when indicated. Refer to licensing order at Statute 144G.11, Subd 4. The licensee failed to ensure assisted living services were provided based on the resident's	0 250		

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0 250	Continued From page 7 needs and according to an up-to-date service plan subject to accepted health care standards. Refer to licensing order at Statute 626.557, Subd 3. The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation, and implement the facility's written procedures pertaining to allegations of resident maltreatment. Refer to licensing order at Statute 626.557, Subd 4, a. The licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation, and implement the facility's written procedures pertaining to allegations of resident maltreatment. Thirty (30) correction orders were issued, which indicated the licensee's understanding of the Minnesota statutes and Rules were limited or not evident for compliance with sections 144G.08 to 144G.9999. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 250		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the	0 480		

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0 480	Continued From page 8 recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report, dated December 14, 2021, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		

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0 510	Continued From page 9	0 510		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards related to COVID-19; and failed to ensure appropriate infection control practices were implemented during personal cares and delegated treatments/therapies for two of two residents (R1 and R2); and failed to ensure food items were maintained at appropriate and safe temperatures to minimize the potential for foodborne illness for three of twelve residents (R1, R11 and R12) who received meals in their rooms. 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	0 510		

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0 510	Continued From page 10 of the residents). The findings include: COVID-19 During the entrance conference on December 13, 2021, at 11:00 a.m., the licensee reported a staff vaccination rate of 50%. Executive Director (ED)-P and registered nurse (RN)-A indicated the licensee recently had two staff members test positive for COVID-19, and the facility was in outbreak status (defined as either a staff member or resident who tested positive for COVID-19). On December 13, 2021, at 7:00 p.m., unlicensed personnel (ULP)-M administered medications in the memory care unit, without eye protection. On December 13, 2021, at 7:00 p.m., ULP-M verified the lack of eye protection. R1's COVID-19 symptom screenings (to include temperature, blood oxygenation and symptoms) were not completed on December 2, 3, 4, 7, 8, 10, 11, 12 and 13, 2021. R2's COVID-19 symptom screenings were not completed on December 2, 3, 4, 7, 8, 10, 11, 12 and 13, 2021. On December 16, 2021, at 1:40 p.m., RN-A stated all staff should wear required personal protection equipment, which included a facemask and eye protection. On December 17, 2021, at approximately 3:30 p.m., RN-A stated she was unaware of the lack of consistent symptom screenings for COVID-19. The licensee's policies and procedures regarding	0 510		

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0 510	Continued From page 11 COVID-19 were requested, and Minnesota Department of Health (MDH) guidance, titled "COVID-19: Long-term Indoor Visitation for Nursing Facilities and Assisted Living-type Settings," dated May 20, 2021, was provided. The guidance lacked procedures pertaining to screening residents and recommendations for eye protection. MDH COVID-19 Personal Protective Equipment and Source Control Grids, dated December 7, 2021, noted use of eye protection in areas with high or substantial community spread (Minnesota was considered high community spread during the survey). The Centers for Disease Control and Prevention (CDC) guidance, dated September 10, 2021, included recommendations to monitor residents daily for COVID-19, including temperature, symptoms consistent with COVID-19, and assessment of oxygen saturation. Additional documentation of symptom screenings were requested, but not provided. INFECTION CONTROL-DELEGATED TASKS-PERSONAL CARES On December 13, 2021, at 4:15 p.m., ULP-G assisted R1 with blood glucose monitoring (blood sugar levels). ULP-G pierced R1's finger, placed R1's blood on the blood glucose monitoring strip, placed the blood glucose monitoring strip in the machine, and reported a result of 381 (normal typically 60-120). Without removing gloves or sanitizing hands, ULP-G obtained R1's Novolog (short acting) insulin pen and dialed to the correct dose of 4 units. ULP-G administered the Novolog to R1, then removed the needle and placed the insulin pen back in a locked box.	0 510		

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0 510	Continued From page 12 On December 13, 2021, at approximately 4:20 p.m., ULP-G verified she did not remove gloves and sanitize hands after obtaining the blood glucose result; ULP-G stated she had not received instruction to do so. On December 13, 2021, at 6:00 p.m., ULP-F assisted R2 with incontinence cares. ULP-F removed R2's wet incontinence pad, which contained dark orange urine. Without removing gloves and sanitizing hands, ULP-F applied a new pad on R2, and adjusted R2's bed linen. On December 13, 2021, at approximately 6:05 p.m., ULP-F stated she usually removed gloves and sanitized hands after removing a soiled incontinence pad. On December 16, 2021, at 3:45 p.m., RN-A stated ULPs' hands should be sanitized before and after obtaining blood glucose and after changing a soiled incontinence pad. The licensee's Infection Control Hand Washing policy, dated August 1, 2021, noted hands should be washed or "decontaminated" if moving from a contaminated body site to a clean body site during resident care. In addition, hands should be decontaminated after contact with equipment and after removing gloves. FOODBORNE ILLNESS On December 13, 2021, at approximately 4:50 p.m., dinner was delivered to the memory care unit in warmed serving containers on a cart. In addition, breakfast for December 14, 2021, was observed on the bottom of the cart. Breakfast included hard boiled eggs, muffins, milk and juice.	0 510		

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0 510	Continued From page 13 On December 13, 2021, at 5:30 p.m., unlicensed personnel (ULP)-F and ULP-G delivered dinner to residents who remained in their rooms (approximately 12 residents). ULP-F and ULP-G used the cart with December 14th's breakfast on the bottom of the cart to deliver dinner to the residents. On December 13, 2021, from approximately 5:40 p.m. to 5:45 p.m., ULP-F and/or ULP-G delivered dinners to R1, R11 and R12. The surveyor observed two Styrofoam containers in R1's room - one with an egg, and muffin, and the other with meatloaf and mashed potatoes. ULP-F and ULP-G indicated the Styrofoam containers were from breakfast and lunch the same day. R11 and R12's room also had closed Styrofoam containers with meat loaf and mashed potatoes. The meals in R1, R11 and R12's Styrofoam containers included most, if not all, of the meals of meat loaf and mashed potatoes. On December 13, 2021, at 6:00 p.m., the lower portion of the cart, which contained food items for December 14, 2021, remained unrefrigerated. The eggs were warm to touch. Executive Director (ED)-P was requested to obtain a temperature for the eggs. ED-P obtained a temperature of 70 degrees. R1's Universal Assessment Tool, dated December 7, 2021, included diagnoses of dementia and diabetes. R11's undated service plan included a diagnosis of dementia. The resident roster (a list of residents with diagnoses and room numbers) noted R12's	0 510		

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0 510	Continued From page 14 diagnoses included Alzheimer's disease (a neurological disease characterized by loss of mental ability severe enough to interfere with normal activities of daily living). On December 14, 2021, at approximately 12:30 p.m., the Minnesota Department of Health's Sanitarian Supervisor (MDHSS)-T stated hardboiled eggs were considered a time/temperature food for safety. MDHSS-T indicated food left for greater than four hours could support growth of foodborne pathogens. On December 16, 2021, at 11:30 a.m., registered nurse (RN)-A stated food items (Styrofoam containers) left in R1, R11 and R12's rooms should be picked up following meals. RN-A verified food items left in the residents' rooms and consumed later could result in foodborne illness. On December 16, 2021, at 4:15 p.m., certified food protection manager (CFPM)-S verified 70 degrees was not an acceptable temperature for eggs and indicated the eggs were disposed after the temperature was obtained. CFPM-S stated food items for the following day should have been immediately placed in the refrigerator. CFPM-S stated there were a lot of new staff in the memory care unit. The licensee's Food Service policy, dated July 25, 2021, noted food was prepared and served according to the Minnesota Food Code, chapter 4626. The Department of Health, Department of Agriculture, Minnesota Food Code, 4626.0408 B (3), dated April 2021, stated the food must be cooked and served, served at any temperature if ready-to-eat or discarded within 4 hours from the	0 510		

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0 510	Continued From page 15 point in time when the food is removed from temperature control (p1). See below for definition of p1. The Department of Health, Department of Agriculture, Minnesota Food Code, 4626.0020 Subp 65a. Priority 1 item or p1, dated April 2021, stated a Priority 1 item or p1 means a provision in this Code whose application contributes directly to the elimination, prevention, or reduction to an acceptable level of hazards associated with foodborne illness or injury, and there is no other provision that more directly controls the hazard. This is the same as the FDA's "priority designation." The Centers for Disease Control and Prevention (CDC) guidance titled Four Steps to Food Safety: Clean, Separate, Cook, Chill, dated October 15, 2021, indicated bacteria can multiply rapidly if perishable food is left at room temperature, or in the "Danger Zone," between 40°F and 140°F. The guidance stated to never leave perishable food out for more than 2 hours (or 1 hour if exposed to temperatures above 90°F). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 620 SS=G	144G.42 Subd. 6 Compliance with requirements for reporting ma 144G.42 Subd. 6. Compliance with requirements for reporting maltreatment of vulnerable adults; abuse prevention plan. (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and	0 620		

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0 620	Continued From page 16 implement a written procedure to ensure that all cases of suspected maltreatment are reported. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment, and complete a thorough investigation for one of five residents (R2) with records reviewed. In addition, the licensee failed to implement written procedures pertaining to allegations of maltreatment. 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: R2's medical record was reviewed. R2's diagnoses included dementia and anorexia (loss of appetite or inability to eat). R2 was identified as receiving hospice (end of life) services. R2's Universal Assessment Tool, dated December 2, 2021, noted R2 required assistance with dressing and grooming. R2's assessment noted memory loss, inability to understand others, and word-finding difficulty. R2's pain assessment dated September 13, 2021, described R2's body language (related to pain) as "fidgeting."	0 620		

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0 620	Continued From page 17 R2's hospice orders dated December 2, 2021, included morphine (a narcotic pain medication) administration five milligrams (mg) four times a day. ALLEGATION OF NEGLECT On December 14, 2021, at 1:15 p.m., family member (FM)-I reported to the surveyor that she assisted R2 with personal cares "last Friday night" including assisting with her pajamas (December 3, 2021). FM-I stated she returned to the licensee on Saturday at 2:30 p.m. (December 4, 2021). FM-I stated R2 had not been cared for since FM-I left the licensee on December 3, 2021. FM-I stated R2 was still in the pajamas she was dressed in on December 3, 2021. FM-I stated R2's incontinence pad was "loaded" with urine and stool. FM-I stated she was upset, and immediately sought assistance from unlicensed personnel (ULP)-M. FM-I indicated at the time, she was not provided with any answers regarding R2's apparent lack of care assistance. FM-I stated she reported the incident to executive director (ED)-P and registered nurse (RN)-A on Monday December 6, 2021. FM-I stated ED-P and RN-A stated they would "look into" the incident. During an interview on December 14, 2021, at 2:00 p.m., ED-P and RN-A indicted R2 had an unwitnessed fall (another incident) and mentioned an additional incident regarding a staff member who "falsified" R2's medication record and was sleeping on the job (see below allegation of staff member). ED-P and RN-A verified the lack of care incident was not reported to MAARC. RN-A stated she spoke with the ULPs that worked on December 4, 2021. The ULPs reported personal cares were provided to R2. RN-A stated she did	0 620		

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0 620	Continued From page 18	0 620		

not have any documentation of the investigation. RN-A verified she was unable to provide the dates and times of individuals who were interviewed, including ULP-M, who assisted R2 after FM-I sought assistance on December 4, 2021. RN-A and ED-P verified the licensee had cameras in the memory care unit, and they had the capability to view when and who entered R2's room, including how long they were in the room. RN-A and ED-P verified they had not viewed the footage. RN-A stated FM-I was offered a complaint form, and FM-I did not want to complete the form. RN-A indicated FM-I's reluctance to complete a compliant form was the reason why the allegation was not called into MAARC, and why the incident was not investigated. RN-A and ED-P stated the allegation by FM-I was considered abuse and neglect. The surveyor directed the licensee to report the incident to MAARC.

A review of the staffing schedule for December 4, 2021, from 6:30 a.m. to 2:30 p.m., indicated there were two ULPs working. The RN was also on-call.

During the entrance conference on December 13, 2021, at 11:00 a.m., ED-P and RN-A indicated the unit where R2 resided was staffed with three ULPs during the day and evening shifts, and RN-B Monday-Friday, 8:00 a.m. to 4:30 p.m.

ALLEGATION OF STAFF MEMBER
A Medication Incident Report, dated December 5, 2021, noted R2's morphine, 5 mg was not administered on December 5, 2021, at 8:00 a.m. and 12:00 p.m. The incident report narrative noted, "Both 8:00 a.m. and 12:00 p.m. doses were documented given at 1:07 p.m. Neither dose was popped out of the bubble card or

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0 620	Continued From page 19 signed out in narc [narcotic book] book." The corrective action noted "write-up." On December 14, 2021, at 2:00 p.m., ED-P and RN-A indicated an employee was sleeping on the job December 5, 2021, and that R2's morphine was not administered as directed. RN-A indicated R2's medication administration record (MAR) was falsified, indicating the morphine was administered. ED-P and RN-A reported the employee was terminated. ED-P and RN-A did not respond when the surveyor asked if there were possibly other residents in similar situations, or if other residents did not receive cares or medications as directed. On December 15, 2021, at 10:30 a.m., RN-A verified R2's morphine omission, allegation of an employee sleeping on the job, and the employee's subsequent termination was not reported to MAARC. The surveyor directed the licensee to report the incident to MAARC. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, defined maltreatment as neglect, abuse and exploitation. The policy noted the director of nursing and ED were responsible for investigating and reporting incidents (no later than 24 hours after the maltreatment was first suspected) any incident of suspected maltreatment. The investigation will begin as soon as a report is received. As part of the internal investigation, the director of nursing and ED will: - interview witnesses or persons who may have information concerning the incident - document the witness statements concerning the incidents - review the resident's care plan and relevant	0 620		

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0 620	Continued From page 20 chart records and agency policies - review the witness statements, resident records, resident's individual abuse protection plan, and agency policies to determine whether abuse or neglect has occurred, including standards of care, that may have been violated No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 620		
0 630 SS=E	144G.42 Subd. 6 Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement individual abuse prevention plans that included individualized assessments of the resident's susceptibility to abuse by another individual, including other vulnerable adults and self-abuse; the resident's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse for three	0 630		

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	31968	A. BUILDING: _____ B. WING _____	12/17/2021

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MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

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0 630	Continued From page 21 of five residents (R1, R2, and R5) 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 Vulnerability Assessment/Abuse Prevention Plan dated December 8, 2021, lacked specific measures to be taken to minimize the risk of abuse regarding refusals of cares, including repositioning and toileting. R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and dementia. The assessment indicated R1 required full assistance with dressing, grooming, transferring, and bed mobility. The assessment noted behavioral symptoms, including resistive to cares and medications. The assessment included a brief interview for mental status (BIMS) dated March 30, 2020, with a score of 9 (indicating moderate impairment). R1's weekly wound record dated December 7, 2021, described R1 with "pressure ulcers" (a type of injury that breaks down the skin and underlying tissue when an area of skin is placed under constant pressure for certain period causing inadequate blood flow to the tissue). The areas	0 630		

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0 630	Continued From page 22 included the following: -Right lateral hip stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer that measured 1 centimeter (cm) x 2 cm with depth of 0.1 cm -Right lateral thigh stage 2 pressure ulcer that measured 2 cm x 2.5 cm with depth of 0.1 cm -Coccyx stage 2 pressure ulcer "butterfly sore" with no description of measurements -Right lateral thigh stage 2 pressure ulcer that measured 6 cm x 7 cm with depth of 0.1. cm On December 16, 2021, at 11:30 a.m., registered nurse (RN)-A and RN-B verified R1 had pressure injuries and refused toileting and repositioning assistance. RN-A and RN-B verified R1's refusals of toileting and repositioning assistance were not identified, nor were specific measures specified in writing for staff to follow regarding R1's refusals. RN-B stated she instructed staff to report refusals of repositioning and toileting, however this was not specified on R1's individual abuse prevention plan. R2 R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services. R2's Vulnerability Assessment/Abuse Prevention Plan dated September 14, 2021, indicated R2 was a wandering/elopement risk, and staff were to monitor the resident's whereabouts. The assessment/plan noted staff were to monitor for symptoms of abuse or neglect from others and report to the nurse promptly. The assessment/plan was not updated to reflect R2's current status, and the plan was not followed when an allegation of abuse was reported.	0 630		

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0 630	Continued From page 23 R2's Universal Assessment Tool dated December 2, 2021, noted R2 required assistance with dressing and grooming. R2's assessment noted memory loss, inability to understand others, and word-finding difficulty. On December 14, 2021, at 1:15 p.m., family member (FM)-I reported to the surveyor that she assisted R2 with personal cares "last Friday night" including assisting with pajamas (December 3, 2021). FM-I stated she returned to the licensee on Saturday at 2:30 p.m. (December 4, 2021). FM-I stated R2 had not been cared for since FM-I left the licensee on December 3, 2021. FM-I stated R2 was still in the pajamas she was dressed in on December 3, 2021. FM-I stated R2's incontinence pad was "loaded" with urine and stool. FM-I stated she was upset, and immediately sought assistance from unlicensed personnel (ULP)-M. FM-I stated she reported the incident to executive director (ED)-P and RN-A on Monday December 6, 2021. On December 16, 2021, at 1:40 p.m., RN-A and RN-B verified R2 was no longer at risk for wandering and elopement, was totally dependent on staff for all cares, and the individual abuse prevention plan was not updated to reflect R2's current condition. RN-A and RN-B did not verify R2's individual abuse prevention plan was not followed, when an allegation of neglect was reported. R5 R5's Vulnerability Assessment/Abuse Prevention Plan dated April 22, 2020, indicated R5 was not at risk for elopement and lacked identification and direction for when R5 experienced auditory hallucinations.	0 630		

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0 630	Continued From page 24 R5's medical record included diagnoses of schizophrenia, diabetes mellitus, delusional disorders, psychosis and alcohol dependence. R5's service plan dated July 31, 2020, indicated R5 received services including monitoring for signs and symptoms of auditory hallucinations, medication administration, Juxtalight wraps (compression wraps), monthly vital signs and wound care. R5's progress notes, late entry on November 19, 2021, for November 15, 2021, indicated R5 left the licensee's building without informing staff for an extended period of time because he was looking for another place to live due to delusions of "there's eyes in there" and indicating he did not have privacy. An incident report, dated November 19, 2021, indicated R5 had left the licensee's building without informing staff from approximately 6:30 p.m. on November 18, 2021 and returned to the facility on November 19, 2021 at approximately 1:45 p.m. Staff were unaware of R5's location and safety. On December 14, 2021, at 2:45 p.m., RN-O stated she did not feel that R5 was as risk for elopement despite having gone missing twice. RN-O indicated R5's auditory hallucinations did not make him vulnerable. The licensee's 6.05 Individual Abuse Prevention Plan policy, dated August 1, 2021, noted all residents in an assisted living are categorically considered vulnerable adults and for purposes of the abuse prevention plan, abuse includes self-abuse. The policy noted an individual abuse prevention plan was developed and implemented	0 630		

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0 630	Continued From page 25 on all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. (b) Each employee record must be retained for at least three years after a paid employee, volunteer, or contractor ceases to be employed by, provide services at, or be under contract with the facility. If a facility ceases operation, employee records must be maintained for three	0 650		

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0 650	Continued From page 26 years after facility operations cease. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure current employee records were maintained to include all required content for two of four unlicensed personnel ((ULP)-D and ULP-E) 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: ULP-D ULP-D was hired on October 12, 2021, to provide direct care services to residents at the assisted living facility. ULP-D's employee record lacked documentation that ULP-D had received training and was competent in the following: -orientation to assisted living regulations prior to providing services to include: overview of assisted living statutes, review of provider's policies and procedures, handling emergencies and using emergency services, reporting maltreatment of vulnerable adults, assisted living bill of rights, handling of resident complaints, reporting of complaints and where to report complaints, consumer advocacy services, review of the types of assisted living services the employee would provide and the provider's scope	0 650		

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0 650	Continued From page 27 of license and principles of person-centered service delivery; -eight hours of dementia training; -current job description; -tuberculosis (TB) training; -basic infection control, including blood borne pathogens, maintenance of a clean and safe environment, training on the prevention of falls for providers working with the elderly or individuals at risk of falls, communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family, awareness of confidentiality and privacy, understanding appropriate boundaries between staff and residents and the resident's family, procedures to utilize in handling various emergency situations, awareness of commonly used health technology equipment and assistive devices, basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel, recognizing physical, emotional, cognitive, and developmental needs of the resident. On December 16, 2021, at 9:30 a.m., registered nurse (RN)-C confirmed ULP-D had completed all the above training and competency tests; however, the documentation had been misplaced, and RN-C was unable to locate it. RN-C confirmed ULP-D's employee file lacked a job description due to the licensee's change in protocol for receiving and signing job descriptions electronically. On December 16, 2021, at 10:00 a.m., ULP-D confirmed he had completed all the above training and competency tests and had returned all documentation to RN-C and RN-A.	0 650		

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0 650	Continued From page 28 ULP-E ULP-E was hired on October 26, 2021, to provide direct care services to residents at the assisted living facility. ULP-E's job description dated October 21, 2021, lacked identification of staff persons providing supervision of ULP-E. On December 16, 2021, at 9:45 a.m., RN-A confirmed the job description for ULP-E lacked identification of the supervisor for ULP-E's role. The licensee's 5.01 Orientation of Staff and Supervisors & Content and 5.10 Training Records policies, dated August 1, 2021, both noted a record would be maintained of staff training and competency required, as well as the staff person's job description upon hire and whenever there is a change to the job description. A policy and procedure pertaining to job description was requested, but not provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 29 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 interview and record review, the licensee failed to have a written emergency preparedness plan with all the required content as defined in Appendix Z. 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:	0 680		

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0 680	Continued From page 30 The licensee's Emergency Preparedness Assisted Living Facility Operations Plan, dated July 15, 2021, lacked the following required content: -development of policies and a plan to include emerging infectious diseases (EID); -subsistence needs for staff and residents, including policies and procedures addressing the following: alternate sources of energy to maintain temperatures to protect resident health and safety, safe and sanitary storage of provisions, emergency lighting, and sewage and waste disposal; -development of policies and procedures to shelter in place for residents, staff and volunteers who remain in the facility; -development of a communication plan with the following required content: names and contact information for staff/entities providing services under an agreement, residents' physicians, other facilities, volunteers, federal, state, tribal, regional, and local emergency preparedness staff, state licensing and certification agency, Office of the State Long Term Care Ombudsman, other sources of assistance, a plan for communicating during an emergency, including primary and alternative means for communication, procedures for sharing medical information to maintain continuity of care; and procedures for sharing the emergency plan with family members and residents; and -development of emergency preparedness training program. On December 15, 2021, at approximately 11:20 a.m., executive director (ED)-P stated the licensee's emergency preparedness plan was in continued development. ED-P indicated the licensee had policies related to COVID-19 however did not have a general policy related to	0 680		

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0 680	Continued From page 31 EIDs. ED-P stated the licensee ordered overstock of supplies, however, did not have a contract or a plan developed to maintain energy sources in a shelter in place situation. ED-P indicated the licensee had another tool called Shelter in Place Guidelines. ED-P stated staff training was incorporated into quarterly all staff meetings, as well as sending out reminders and policies, however ED-P did not provide evidence of training plan. Shelter in place guidelines and evidence of staff training on emergency preparedness were requested although not provided. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any;	0 730		

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0 730	Continued From page 32 (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the resident record included documentation of complaints, including any resolution, for one of five residents (R2) with record reviewed, and failed to ensure resident incidents, including actions taken in response to the needs of resident, were documented in the record for one of five residents (R5) with records	0 730		

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0 730	Continued From page 33 reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 R2's record lacked documentation of a complaint, including resolution of the complaint. On December 14, 2021, at 1:15 p.m., family member (FM)-I reported she assisted R2 with personal cares "last Friday night" including assisting with pajamas (December 3, 2021). FM-I stated she returned to the licensee on Saturday at 2:30 p.m. (December 4, 2021). FM-I alleged R2 had not been cared for since she left the licensee on December 3, 2021. When asked to describe R2's condition, FM-I stated R2 was still in the pajamas she was dressed in on December 3, 2021. FM-I stated R2's incontinence pad was "loaded" with urine and stool. FM-I stated that she was upset, and immediately sought assistance from two unlicensed personnel (ULPs), including ULP-M. FM-I indicated at the time, she was not provided with any answers regarding R2's apparent lack of care assistance. On November 16, 2021, at 1:40 p.m., registered nurse (RN)-B verified FM-I's complaint was not documented in R2's record.	0 730		

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0 730	Continued From page 34 R5 R5's record lacked documentation of an incident on November 18, 2021, in which R5 was missing from the assisted living facility from approximately 3:45 p.m., until 1:45 p.m. on November 19, 2021. A Record of Concern dated November 19, 2021, outlined the incident and follow-up investigation, however the incident was not noted in R5's record, nor were the licensee's actions taken in response to the incident. The Record of Concern noted on November 18, 2021, executive director (ED)-P witnessed R5 leave the building at approximately 3:45 p.m. At 7:15 p.m., an unidentified ULP noted R5 was not in his apartment and was unable to locate R5. At 10:20 p.m., an unidentified ULP notified RN-C. RN-C instructed the unidentified ULP to notify her if R5 returned during the night. On the morning of November 19, 2021, RN-A was notified at 7:30 a.m., that R5 had not yet returned. Camera footage was reviewed by the licensee and showed R5 left the building at 6:30 p.m. R5 returned on November 19, 2021, at 1:45 p.m., stating he had "walked around all night to stay out of the wind, but did not sleep." The licensee sent R5 to the hospital for concerns of psychiatric and physical health. R5's progress note dated November 19, 2021, at 2:11 p.m., indicated R5 returned to the licensee's building on his own, and was immediately sent to the hospital for evaluation and treatment. R5's progress note dated November 21, 2021, at 8:23 a.m., indicated R5 returned from the hospital on November 19, 2021, at 5:00 p.m., with no new orders. On December 15, 2021, at approximately 9:50	0 730		

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0 730	Continued From page 35 a.m., RN-A confirmed R5's record contained "minimal documentation" of the event occurring November 18, 2021. The licensee's Resident Record-Documentation policy, dated August 1, 2021, noted staff will document other important and pertinent information relating to each resident including: new problems, communication, a change in condition and incidents. The policy lacked procedures for ensuring complaints and resolution of complaints were included the record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
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 36 (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 interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements; failed to provide required employee training on fire safety and evacuation; failed to provide training on fire safety and evacuation to residents capable of self-evacuation; and failed to complete required employee evacuation drills. This had the potential to affect all staff, residents, 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: A record review and interviews were conducted	0 810		

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0 810	Continued From page 37 on December 16, 2021 at approximately 10:45 a.m. with the Chief Executive Officer (CEO)-Q and the Director of Maintenance (DM)-R on the fire safety and evacuation plan, fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. Record review of the fire safety and evacuation plan indicated that the plan did not have provisions for employee actions to be taken in the event of a fire or similar emergency, provisions for actions to be taken for residents who are capable of self-evacuation, and 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. During interview, DM-R stated that the licensee did not have a policy or a fire safety and evacuation plan that included these items. Record review of the fire safety and evacuation training indicated that employees did not receive training twice per year after initial hire and that residents capable of self-evacuation were not provided with the option of training at least once per year. During interview, DM-R stated that the licensee provided training to employees at the time of hire but did not prescribe that they receive training twice per year after the initial hire on the fire safety and evacuation plan as required by statute. A policy was requested but one was not provided. Record review of the fire safety and evacuation drills indicated that evacuation drills for employees had not been performed every other month as required. During interview, DM-R stated that evacuation drills had not been performed for the employees at the time of survey. A policy was	0 810		

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0 810	Continued From page 38 requested on evacuation drills for employees, but one was not provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the	01440		

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01440	Continued From page 39 date on which the individual begins working for the licensee for one of two unlicensed personnel (ULP)-E with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 15, 2021, at 7:15 a.m., ULP-E administered medication to R5. ULP-E was hired on October 26, 2021, to provide direct care services to residents at the assisted living. ULP-E's employee record lacked documentation of a registered nurse (RN) supervising ULP-E performing delegated tasks within 30 days of beginning work with the licensee. During an interview on December 15, 2021, at 7:15 a.m., ULP-E confirmed she had not received a supervisory visit by the RN of her performing medication administration or any other tasks. ULP-E stated she knew the RN had observed other employees perform medication administration although she had not been observed. On December 16, 2021, at 9:45 a.m., RN-A confirmed ULP-E's 30-day supervision of delegated tasks had been missed.	01440		

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01440	Continued From page 40 The licensee's 6.17 Supervision of Staff - Delegated Services policy, dated August 1, 2021, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual began work and first performed the delegated tasks for residents and documentation of supervision activities would be retained in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01440		
01600 SS=F	144G.70 Subdivision 1 Acceptance of residents An assisted living facility may not accept a person as a resident unless the facility has staff, sufficient in qualifications, competency, and numbers, to adequately provide the services agreed to in the assisted living contract. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure staff were available sufficient in qualifications, competency, and numbers to adequately provide the services agreed to in the assisted living contract for 26 residents who resided in the Assisted Living Facility with Dementia Care (ALFDC). 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	01600		

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01600	Continued From page 41 or has the potential to affect a large portion or all of the residents). The findings include: During the initial conference on December 13, 2021, at 11:00 a.m., executive director (ED)-P and registered nurse (RN)-A indicated the ALFDC unit was staffed with three unlicensed personnel (ULP) during the day and evening shifts, and RN-B on Monday-Friday, 8:00 a.m. to 4:30 p.m. RN-A and ED-P indicated the licensee used one supplemental staffing agency, approximately one or two days/shifts a week. Upon arrival to the ALFDC unit on December 13, 2021, at 4:00 p.m., there were two staff members working in the unit versus the reported three staff members. During observations on December 13, 2021, from 4:00 p.m. to approximately 6:30 p.m., RN-A, RN-B, RN-C and RN-O assisted with meals and resident cares. ULP-G reported about three weeks ago, the unit was short staffed and indicated there was not as much assistance as tonight (December 13, 2021). -Refer to licensing order 144G.91, Subd.4. An immediate order was issued on December 15, 2021, pertaining to R2. Assisted living services were not provided based on the resident's needs and according to an up-to-date service plan subject to and accepted health care standards for two of two residents (R2 and R1). This resulted in harm to R2 and R1. -Refer to licensing order 144G.71, Subd.8. Medications were not issued according to	01600		

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01600	Continued From page 42 prescriber orders, and elevated blood glucose levels lacked assessment and follow-up by the RN. This resulted in harm to R1. -Refer to licensing order 144G.42, Subd.6. Allegations of maltreatment were not reported to the Minnesota Adult Abuse Reporting Center (MAARC), and the licensee did not complete investigations on reported allegations of maltreatment. -Refer to licensing order 144G.42 Sub.6. (b) Individual abuse prevention plans were not developed and/or implemented as required. -Refer to licensing order 144G.41, Subd.3. COVID-19 symptom screens were not conducted as recommended on residents who resided in the ALFDC, and appropriate infection control interventions were not implemented during observations of personal cares and delegated tasks. -Refer to licensing order 144G.70, Subd.2. Residents lacked assessments, reassessments and ongoing monitoring in the ALFDC. -Refer to licensing order 144G.70, Subd.4. Assisted living services were not provided as specified in the service plans. -Refer to licensing order 144G.71, Subd. 3. Medication reassessment was not completed as required following a change in condition. -Refer to licensing order 144G.72, Subd.3. Residents lacked the development of individual treatment and therapy plans. -Refer to licensing order 144G.72 Subd.4.	01600		

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01600	Continued From page 43 ULPs lacked training and competency demonstrations on treatments and therapies provided. -Refer to licensing orders under 144G.84. Residents in the ALFDC were not provided with services in a dignified and person centered approach, and activity plans were not developed as required. On December 15, 2021, ULP-F indicated there was not enough staff to complete all the required tasks. On December 15, 2021, at approximately 10:15 a.m., ULP-L stated the ALFDC was typically short staffed twice per week. On December 15, 2021, at approximately 10:30 a.m., RN-B indicated she had adequate time to complete her duties, verified the licensee did not always have adequate staff, and that she sometimes helped out on the floor with ULP tasks. The staffing schedule from December 1, 2021, through December 12, 2021, was requested. According to the staffing schedule, there were two staff members on the following shifts: December 1, 2021, 6:30 a.m.-2:30 p.m., two ULPs were identified on the schedule and RN-B. December 3, 2021, 6:30 a.m.-2:30 p.m., two ULPs were identified on the schedule and RN-B. December 3, 2021, 2:30 p.m.-10:30 p.m., two ULPs were identified on the schedule. December 4, 2021, 6:30 a.m.-2:30 p.m., two ULPs were identified on the schedule, the RN was on-call. December 8, 2021, 2:30 p.m. to 10:30 p.m, two	01600		

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01600	Continued From page 44 ULPs were identified on the schedule. The licensee's Staffing and Scheduling policy, dated August 1, 2021, noted the licensee assured qualified employees were scheduled to meet the operational requirements and needs of the residents. In addition, the clinical nurse must ensure staffing levels were adequate to address each residents needs, as identified in their service plan, and that staff were able to meet the residents' scheduled and unscheduled needs. The clinical nurse must ensure that staffing levels were adequate to address staff experience, training and competency. TIME PERIOD FOR CORRECTION: Seven (7) days	01600		
01620 SS=E	144G.70 Subd. 2 Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident	01620		

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01620	Continued From page 45 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 resident reassessments and monitoring based on the needs of the residents for three of five residents (R1, R2 and R5) with records reviewed , and four of ten residents (R1, R9, R10 and R11) reviewed in the Assisted Living Facility with Dementia Care with weight fluctuations. 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: REASSESSMENT AND MONITORING R1 R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and dementia. R1's assessment described R1 as requiring full assistance with dressing, grooming, transferring, and bed mobility.	01620		

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01620	Continued From page 46 R1's prescriber orders dated November 18, 2021, indicated Nystatin (topical anti-fungal) powder to affected area (right armpit) twice a day until resolved, and Nystatin powder to irritated skin folds under the breasts, twice a day. R1's record lacked an assessment of the affected areas, as well as ongoing monitoring to determine if the areas were improving, staying the same or worsening with the Nystatin. On December 16, 2021, at 10:30 a.m., R1 refused to allow the surveyor to view the affected skin condition. On December 16, 2021, at 11:30 a.m., RN-A and RN-B verified the lack of skin assessments regarding the areas under the breasts and arms where the Nystatin was applied. R2 R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services. R2's Universal Assessment Tool, dated December 2, 2021, noted R2 required assistance with dressing and grooming. R2's assessment noted memory loss, inability to understand others, and word-finding difficulty. R2's hospice prescriber orders dated December 8, 2021, ordered staff to apply Mepilex (an absorbent dressing) to reddened area on coccyx daily or as needed. R2's record lacked an assessment of the coccyx area, including a description of the area, size and staging. In addition, R2's record lacked an assessment to determine a repositioning	01620		

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01620	Continued From page 47 schedule, to minimize occurrence of pressure injuries and improve the reddened area on the coccyx. R2's record lacked directions for repositioning. On December 13, 2021, at approximately 6:00 p.m., the surveyor observed RN-B and unlicensed personnel (ULP)-F assist R2 to bed . R2's incontinent pad was removed, which was soiled. R2's coccyx area was intact and pink in color. On December 15, 2021, at 10:30 a.m., RN-B verified the lack of an assessment regarding R2's coccyx area, as well as an assessment to determine a repositioning schedule. R5 R5's diagnoses included schizophrenia, Type II diabetes mellitus, delusional disorders, psychosis and alcohol dependence. R5's service plan dated July 31, 2020, indicated R5 received services, including monitoring for signs and symptoms of auditory hallucinations, medication administration, Juxtalight wraps (compression wraps), monthly vital signs and wound care. R5's record included a Uniform Assessment Tool dated October 1, 2021. R5's record lacked any further assessments. On December 13, 2021, at approximately 1:00 p.m., the surveyor was provided with a Record of Concern (incident report) dated November 19, 2021. The incident report indicated R5 was reported missing and was last seen at approximately 3:30 p.m. R5's next scheduled visit was at 7:15 p.m., for bedtime medications. Staff	01620		

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MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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
01620	Continued From page 48 were unable to locate R5. An unidentified ULP notified RN-C at 10:20 p.m. that R5 was still missing and could not be located. RN-C tried calling R5's cell phone. RN-C instructed night staff to notify RN-C if R5 arrived back at the facility during the night. At 7:30 a.m., on November 19, 2021, RN-A was notified R5 was still missing. Cameras were reviewed and verified R5 left the facility at 6:30 p.m. on foot with his four-wheel walker, dressed in shorts, a sweatshirt, hat, and gloves. R5 returned to the facility on November 19, 2021, at 1:45 p.m. R5 said he heard voices and needed to leave, pointing to his head. R5 said he went downtown St. Paul via bus, walked around all night trying to stay out of the wind but did not sleep. R5 returned via bus, nursing checked his blood glucose and provided R5 lunch. The licensee called emergency medical services (EMS) due to concerns for psychiatric and physical health, and R5 was transported to hospital. R5's progress notes included the following entries: -November 19, 2021, at 9:22 a.m.: "Late entry for 11/15/2021 9:30 a.m.: On Sunday night at 9:30 a.m. [writer] received a call from Union Gospel Mission Twin Cities, a homeless shelter. According to employee [writer] spoke with, R5 showed up there but could not provide an explanation for why he was there. He did inform them that he lived at Maple Hill. The police were called by the homeless shelter. [Writer] spoke with an officer at 10:51 p.m., they were wondering if R5 had someone that could come and pick him up ...officer's (sic) decided to escort R5 home. They confirmed with [writer] that he did in fact live at Maple Hill and was safe to return home and would have proper care. [Writer] stated yes. -[Writer] spoke with R5 Monday morning	01620		

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01620	Continued From page 49 regarding the incident. R5 stated he took a bus to the homeless shelter because he wants to find another place to live ...R5 stated he doesn't have any privacy, "there's eyes in there." [Writer] asked if R5 thought there was cameras in his apartment...resident made nonsensicle (sic) statement and changed the subject ..." On December 14, 2021, at 2:45 p.m., RN-O indicated she was not the RN on-call for R5's incidents of going missing. RN-O stated R5 had the right to come and go and had left twice that she was aware of. On December 14, 2021, at 3:20 p.m., RN-A stated R5 was not an elopement risk. RN-A stated an incident report had been completed for the second incident of going missing because it was now a pattern for R5. RN-A confirmed R5 did not sign out for either incident. During an interview on December 15, 2021, at 9:50 a.m., RN-A and RN-C confirmed a change of condition assessment was not completed after R5 went missing on November 15, 2021, or November 18, 2021. RN-C stated it was not a significant change, as R5 had moved upstairs due to behavior. R5 had left on day trips before; however in past, he had signed out. RN-A confirmed R5 had a history of hearing voices due to mental illness; however, he did not begin hearing voices until a medication was discontinued. RN-A stated a change of condition would not be indicated as R5 was not admitted to the hospital, nor had R5 been gone for more than 24 hours. WEIGHTS ASSISTED LIVING FACILITY DEMENTIA CARE (ALFDC): On December 13, 2021, at 5:30 p.m., ULP-F and	01620		

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01620	Continued From page 50 ULP-G delivered dinner to residents who remained in their rooms at mealtimes (approximately 12 residents). A list was posted in the dining room that identified R1, R9, R10, and R11, as receiving meals in their rooms. R1 R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and dementia. On December 13, 2021, at 5:45 p.m., R1's dinner was served in the room. The surveyor observed R1 had several closed Styrofoam containers in the room. One container included an egg and muffin, and another Styrofoam container had meat loaf and mashed potatoes (identified as breakfast and lunch the same day). The Styrofoam containers included most, if not all, of the meals served at breakfast and lunch. R1's weights included the following: September 3, 2021, 151.5 pounds November 3, 2021, 133 pounds (18.5 weight loss) R9 R9's undated service plan included a diagnosis of dementia. R9's service plan directed staff to walk with the resident to the dining area, and make sure she was in the dining room. R9's weights included the following: November 29, 2021, 97 pounds December 6, 2021, 146.2 pounds December 13, 2021, 153 pounds R10 R10's undated service plan included a diagnosis of Alzheimer's disease (a neurological disease	01620		

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01620	Continued From page 51	01620		

characterized by loss of mental ability severe enough to interfere with normal activities of daily living). R10's service plan noted the resident was not always oriented to place and time. R10's service plan directed staff to direct and cue the resident to all meals and assist with meal setup.

R10's weights included the following:
October 16, 2021, 138.4 pounds
December 1, 2021, 96 and then 97 pounds the same day
December 8, 2021, 142 pounds
December 15, 2021, 178 pounds

R11
R11's undated service plan included diagnoses of dementia. R11's service plan noted to remind R11 to go to the dining room for meals.

R11's weights included the following (no weights were recorded in November or December 2021):
September 20, 2021, 80 pounds
September 27, 2021, 84.6 pounds
October 18, 2021, 98 pounds
October 25, 2021, 82.6 pounds

On December 14, 2021, at 2:45 p.m., RN-A stated the licensee provided education for staff regarding weights and indicated discrepancies were noted.

On December 16, 2021, at 11:30 a.m., RN-A stated residents in the ALFDC were not on intake and output, and their dietary intakes were not monitored.

On December 16, 2021, at 1:30 p.m., RN-A indicated weights were not reviewed on a regular basis, and stated weights were not a required service in Assisted Livings, but a service that was

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01620	Continued From page 52 offered. RN-A verified if there were weight losses, the residnets should be assessed. When weight discrepancies were reviewed (as in R9 and R10), RN-A indicated the weights were not accurate. The licensee's Uniform Assessment Tool policy dated June 21, 2021, noted an assessment of the resident's skin condition and nutritional, hydration status and preferences were assessed. The licensee's 6.19 Resident Change in Condition or Need policy dated August 1, 2021, noted initial reviews and scheduled assessments and monitoring were completed as required and change of condition assessments would be initiated after every resident readmission from the hospital, emergency department or other medical/treatment stay. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01620		
01640 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services	01640		

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01640	Continued From page 53 and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident service plans were revised and included a signature or other authentication by the licensee and resident and/or representative for two of five residents (R1 and R2) with records reviewed. The licensee also failed to ensure services were provided as required by the service plan for two of two residents (R1 and R2) with records reviewed and four of four residents (R8, R9, R10 and R11) reviewed in the supplemental sample. 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: SERVICE PLANS NOT AUTHENTICATED: R1	01640		

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01640	Continued From page 54 R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and dementia. R1's signed service plan dated July 30, 2021, lacked the following services, which were included on another unsigned service plan, dated December 14, 2021: -assistance with repositioning -replace Mepilex (absorbent dressing) to coccyx right lateral thigh, three open areas R2 R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services. R2's signed service plan dated September 13, 2021, lacked the following services, which were included on another unsigned service plan, dated December 14, 2021: -mechanical soft diet with nectar thick liquids -follow directions in electronic medication administration record (EMAR) for changing dressing to coccyx and left toe -addition of hospice services On December 17, 2021, at 9:00 a.m., registered nurse (RN)-A verified the service plans dated December 14, 2011, were not authenticated by the licensee and resident and/or resident's representative. RN-A stated when changes in services were initiated, the changes were noted and saved in the computer, but not authenticated; RN-A indicated this was the licensee's practice. SERVICES NOT PROVIDED AS DIRECTED ON SERVICE PLAN: R1 R1's undated, unsigned service plan included:	01640		

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01640	Continued From page 55	01640		

must offload whatever side she was laying on due to new onset of pressure ulcers; provide assistance with toileting before dinner, ensure placement of clean incontinent pad; cut food (especially meats); and bath/shower assistance every Tuesday and Friday.

On December 13, 2021, from 4:15 p.m. to 7:00 p.m., R1 was in bed on her back. The surveyor did not any observe unlicensed personnel (ULPs) provide R1 assistance with repositioning.

On December 13, 2021, at 5:45 p.m., R1 was in bed on her back. The surveyor observed R1 had several closed Styrofoam containers in her room. One container included an egg and muffin (full) and another Styrofoam container included meat loaf (not cut) and mashed potatoes. The surveyor smelled a strong urine odor in R1's room.

On December 14, 2021, at approximately 9:00 a.m., R1 refused oral medications. ULP-K reported R1 had vomited the previous two mornings after receiving medications. R1 was subsequently seen in the emergency room at 12:30 p.m., and admitted to the hospital.

R1's Service Checkoff List (documentation of services provided) dated December 2021, included bath/shower assistance on Tuesdays and Fridays; however, there was no documentation services were provided on December 3, 7, or 11, 2021. R1's documentation noted bath/shower assistance was provided on December 14, 2021, at 9:30 a.m.

On December 16, 2021, at 11:30 a.m., RN-A and RN-B stated documentation indicated R1 was assisted with repositioning and toileting at the designated times, even though on December 13,

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01640	Continued From page 56 2021, from 4:15 p.m. to 7:00 p.m., the surveyor observed R1 on her back. RN-A stated documentation indicated shower assistance was provided at 10:10 a.m. RN-A and RN-B did not comment on the lack of documentation of shower assistance on December 3, 7 or 11, 2021. R2 R2's undated, unsigned service plan included: morning cares, assist resident with grooming, wash face, brush teeth with foam toothettes and brush hair; follow direction in EMAR for changing dressing to coccyx and left toe; toileting assistance at 4:30 p.m.; and evening cares, assist with clean pajamas, assist with grooming, wash face, and brush teeth with toothettes. On December 13, 2021, at approximately 4:15 p.m., ULP-F and ULP-G assisted R2 out of bed. The surveyor did not observe ULP-F or ULP-G assist R2 with incontinent cares, as directed. The surveyor asked ULP-F and ULP-G if R2 was assisted with incontinent care, and ULP-F and ULP-G replied R2 received assistance after dinner. R2's documentation dated December 13, 2021, at 4:30 p.m., indicated ULPs provided toileting assistance to R2. On December 13, 2021, at approximately 6:00 p.m., ULP-F and ULP-G assisted R2 to bed. The ULPs removed R2's incontinent pad, which was soiled with dark orange urine. The surveyor did not observe a Mepilex dressing on R2's coccyx area. R2's coccyx area was intact and pink in color. The surveyor did not observe the ULPs assist R2 with oral cares or face washing. On December 13, 2021, at approximately 6:15	01640		

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01640	Continued From page 57 p.m., the surveyor asked ULP-F and ULP-G if other evening cares were provided to R2. ULP-F and ULP-G indicated R2's cares were completed, other than checking on R2 and providing incontinent care. On December 14, 2021, at approximately 10:30 a.m., the surveyor heard R2 crying in her room from the hall area. Upon entering R2's room, R2 was positioned in a Broda chair (type of chair that tilts to redistribute pressure on skin). On December 14, 2021, at approximately 10:35 a.m., the surveyor asked ULP-L what cares were provided to R2 prior to entering the room. ULP-L reported "we changed her" and transferred R2 to the chair. ULP-L indicated they were going to provide oral cares. But after brushing R2's hair, ULP-L escorted R2 to the dining room without providing assistance with oral cares or face washing. On December 15, 2021, at 10:30 a.m., RN-A stated the licensed staff were supposed to reapply R2's Mepilex dressing and indicated ULPs were supposed to report when it was off; however, R2's service plan directed ULPs to apply the Mepilex. On December 16, 2021, at 1:40 p.m., RN-A stated R2's service plan should be followed related to morning cares and toileting. R8, R9, R10, and R11 On December 13, 2021, at 5:30 p.m., ULP-F and ULP-G delivered dinner to residents who remained in their rooms (approximately 12 residents). A list was posted in the dining room in the ALFDC which identified R8, R9, R10, and R11 as receiving meals in their rooms versus the	01640		

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01640	Continued From page 58 dining room. R8 R8's undated service plan included a diagnosis of dementia. R8's service plan lacked services pertaining to meals. R8's Universal Assessment Tool dated September 9, 2021, directed cues and reminders with meal assistance. R9 R9's undated service plan included a diagnosis of dementia. R9's service plan directed staff to walk with the resident to the dining area, and make sure R9 was in the dining room. R10 R10's undated service plan included a diagnosis of Alzheimer's disease (a neurological disease characterized by loss of mental ability severe enough to interfere with normal activities of daily living). R10's service plan noted R10 was not always oriented to place and time. R10's service plan directed staff to direct and cue the resident to all meals and assist with meal setup. The surveyor did not observe R10 in the dining room on December 13, 2021, for dinner or December 14, 2021, for breakfast. R11 R11's undated service plan included a diagnosis of dementia. R11's service plan directed staff to remind R11 to attend the dining room for meals every day. The surveyor did not observe R11 in the dining room on December 13, 2021, for dinner or December 14, 2021, for breakfast.	01640		

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01640	Continued From page 59 On December 16, 2021, at 11:30 a.m., RN-A stated she was unaware residents were served meals in Styrofoam containers in their rooms. RN-A verified residents who require assistance with cues and reminders for meals should not receive their meals in the rooms without supervision. On December 16, 2021, at 4:15 p.m., Certified Food Protection Manager (CFPM)-S stated she assumed the use of Styrofoam containers was initiated because of COVID-19, when residents remained in their rooms. CFPM-S stated she was working with nursing to "figure out" who was not going to the dining room and why. The licensee's Service Plan policy dated August 1, 2021, noted the service plan and any revisions shall include a signature or other authentication by staff and by the resident and/or resident's representative, documenting agreement on the services provided. The policy noted services were implemented and provided all services indicated on the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01640		
01650 SS=F	144G.70 Subd. 4 Service plan, implementation, and revisions t (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;	01650		

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01650	Continued From page 60 (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 (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 the required content for five of five residents (R1, R2, R4, R5 and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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).	01650		

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01650	Continued From page 61 The findings include: R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and dementia. R1's signed service plan dated July 30, 2021, lacked the following: -the fees for services; and -the identification of staff or categories of staff who will provide the services. R2's medical record included diagnoses of dementia and anorexia. R2's signed service plan dated September 13, 2021, lacked the following: -the fees for services; and -the identification of staff or categories of staff who will provide the services. R4's diagnoses included Type II diabetes mellitus, Charot's joint of right foot and ankle (a complication of diabetes that affects the bones, joints, and soft tissues of the foot and ankle), pain and hypertension. R4's service plan, dated June 17, 2021, lacked the following: -the fees for services; and -the identification of staff or categories of staff who will provide the services. R5's diagnoses included schizophrenia, Type II diabetes mellitus, delusional disorders, psychosis and alcohol dependence. R5's service plan dated July 31, 2020, lacked the following: -the fees for services; and	01650		

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01650	Continued From page 62 -the identification of staff or categories of staff who will provide the services. R6's diagnoses included bipolar disorder, type II diabetes mellitus, depression and anxiety. R6's service plan dated February 22, 2021, lacked the following: -the fees for services; and -the identification of staff or categories of staff who will provide the services. On December 14, 2021, at 2:30 p.m., registered nurse (RN)-O confirmed the same service plan template was used for all residents and verified it did not include all required content. The licensee's 6.08 Service Plan policy, dated August 1, 2021, noted a service plan would include: fees for services to be provided and an identification of staff or categories of staff who will be providing services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas The assisted living facility must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced	01710		

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01710	Continued From page 63 by: Based on observation, interview and record review, the licensee failed to ensure reassessment and monitoring of medication management services for one of five residents (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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services. R2's medication management assessment and management plan, dated September 13, 2021, noted the assessment was conducted face-to-face and included a review of the medications. R2's Universal Assessment Tool dated December 2, 2021, noted all medications were reviewed, however, lacked identification of medications since the initiation of hospice to include: morphine 5 milligrams (mg) four times a day for pain (dated December 2, 2021) and lorazepam 0.5 mg every four hours for agitation/anxiety (dated October 10, 2021). R2's Universal Assessment Tool and medication management assessment lacked assessments to determine if R2's pain control was adequate with the current	01710		

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01710	Continued From page 64 dose of morphine, or if an increase or decrease was warranted. During an observation on December 13, 2021, at 4:30 p.m., unlicensed personnel (ULP)-F and ULP-G assisted R2 from the bed to wheelchair. During the transfer, R2 was crying out "ow" and moaning. ULP-F and ULP-G reported R2 had pain, and this was not uncommon. During an observation on December 14, 2021, at approximately 10:30 a.m., the surveyor heard R2 crying in her room from the hall area. The surveyor entered R2's room, and ULP-H and ULP-L were assisting R2 with morning cares. ULP-H and ULP-L reported R2 was in pain, and had received morphine (narcotic analgesic) at 8:00 a.m. On December 16, 2021, at 1:40 p.m., the surveyor asked registered nurse (RN)-A if a reassessment of R2's medications was completed. RN-A stated typically the hospice provider reassessed the medications, and "I don't know of any facility that can monitor all the meds." The licensee's Uniform Assessment Tool policy dated August 1, 2021, noted a review of medications was completed for each medication, which included the reason taken, side effects, dosage, frequency of use, and any difficulties the resident faced taking the medications. The licensee's Assessments, Reviews & Monitoring policy dated August 1, 2021, noted resident reassessments and monitoring must be conducted as needed based on changes in the needs of the resident. In addition, ongoing medication management and monitoring was	01710		

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01710	Continued From page 65 completed when the resident presented with symptoms, or other issues that may be medication related. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to specify in writing, specific instructions for each resident and document those instructions in the resident record for one of five residents (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	01750		

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01750	Continued From page 66 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's prescriber orders dated December 2, 2021, indicated morphine 5 milligrams (mg) solutab (administered under the tongue, and dissolves) four times a day for pain. On December 13, 2021, at 4:10 p.m., unlicensed personnel (ULP)-G prepared R2's morphine (narcotic analgesic) for administration. ULP-G placed the medication in a cup, added .03 milliliters (ml) of water, and dissolved the medication prior to administering it via syringe. ULP-G verified there were no directions in writing specified by the registered nurse (RN) regarding how staff should administer the medication. On December 16, 2021, at 1:40 p.m., RN-B verified she had instructed some individuals to administer the morphine as noted above. RN-B verified the lack of specific directions for ULPs. The licensee's Delegation of Assisted Living Services policy dated June 2021, noted the RN specified in writing, specific instructions for each resident and documented those instructions in the record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

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01760	Continued From page 67	01760		
01760 SS=G	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 as prescribed by the physician for one of five residents (R1) with records reviewed. 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: R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and	01760		

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01760	Continued From page 68 dementia. R1's progress notes dated December 1, 2021, noted, "Resident was seen by PCP [primary care provider] today. Order to increase Levemir (long-acting insulin) to 27 units;" in addition to Novolog (short-acting insulin) to 4 units twice a day. R1's medication administration record (MAR) dated December 2021, included documentation of Levemir 24 units bring administered, versus the prescribed dose of 27 units, until the time of R1's hospitalization on December 14, 2021. R1's December 2021 MAR included blood glucose (BG) monitoring three times a day. R1's December 2021 MAR directed unlicensed personnel (ULP) to notify the nurse if BG was above 450. R1's MAR noted BG levels above 450 on the following days: December 5, at 4:30 p.m., BG 479 December 7, at 11:50 a.m., BG 512 December 9, at 4:30 p.m., BG 490 December 14, at 9:30 a.m., BG 503 On December 14, 2021, at 9:00 a.m., ULP-K entered R1's room and obtained a BG of 502. ULP-K reported R1 had vomited after oral medications were administered the previous two days. R1 requested milk from ULP-K. ULP-K obtained the milk and placed it on R1's side table. R1 was lying flat in bed, and ULP-K did not assist R1 to sit up and drink the milk but left the room. On December 14, 2021, at 10:00 a.m., the surveyor asked registered nurse (RN)-B if R1's high BG was reported, as well as the complaints of nausea and vomiting. RN-B stated the elevated BG was not reported, and she had noticed it was	01760		

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elevated during the conversation with the surveyor at the same date and time.

R1's record lacked documentation the nurse was notified of R1's BG levels above 450 (December 5, 7, and 9, 2021) or what, if any, interventions were implemented to meet R1's needs.

On December 14, 2021, R1 was transferred to the emergency room and evaluated at 12:30 p.m. R1 was subsequently admitted to the hospital.

R1's Emergency Department notes dated December 14, 2021, included a diagnosis of diabetic ketoacidosis (a serious complication of diabetes that occurs when the body produces high levels of blood acids called ketones) and ketones (a buildup of fatty acids in the bloodstream leading to serious complications) in the urine. R1's BG was 571 in the emergency room and an insulin drip was initiated.

On December 16, 2021, at 11:30 a.m., RN-B stated she did not know if ULPs reported R1's elevated BG levels or not. RN-B stated she typically assessed and documented the actions taken in the progress notes. RN-A and RN-B stated they were unaware of the Levemir error and would investigate. RN-A described the incident as a pharmacy error versus an error by the licensee.

The licensee's Medication & Treatments Medication Error policy dated August 1, 2021, noted the licensee had a goal of no medication errors. If an error occurred, staff documented, tracked, and resolved medication errors for quality improvement. The policy directed the licensed nurse to contact the provider and update them on the details of the error. Follow up by the

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01760	Continued From page 70 nurse should be completed in a timely manner to reduce any risk of adverse outcomes for the client to implement interventions that may reduce the risk of future errors. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01820 SS=D	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriber orders were obtained for one of five residents (R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 14, 2021, at 7:15 a.m., unlicensed personnel (ULP)-E administered the following	01820		

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medications to R5: acetaminophen (analgesic) 500 milligrams (mg); aspirin (blood thinner) 81 mg; vitamin (treats low vitamin D) D3 25 micrograms (mcg); docusate (laxative) 100 mg; doxycycline (antibiotic) 100 mg; ferrous sulfate (treats anemia) 40 mg; Lasix (diuretic) 40 mg; Glucotrol (anti-diabetic) 5 mg; lisinopril (antihypertensive) 20 mg; metformin (anti-diabetic) 1000 mg; multivitamin; Nuplazid (antipsychotic) 34 mg; potassium chloride (treats low potassium) 20 milliequivalents (mEq); hydrocodone-acetaminophen (narcotic analgesic) 5/325 mg; MiraLAX (laxative) 17 grams (g); Seroquel (antipsychotic) 25 mg; and Depakote (mood stabilizer) 125 mg.

R5's diagnoses included schizophrenia, Type II diabetes mellitus, delusional disorders, psychosis and alcohol dependence.

R5's service plan dated July 31, 2020, indicated R5 received services, including medication administration.

R5's prescriber orders dated November 9, 2021, November 23, 2021 and December 2, 2021, included orders for skin prep to wound care three times weekly; Seroquel 12.5 mg by mouth twice daily for schizophrenia; Depakote 125 mg by mouth twice daily and increasing Seroquel to 25 mg twice a day for three days then increase to 25 mg three times a day; hold for sedation.

R5's medication administration record (MAR) dated November 1 through December 14, 2021, indicated the following medications were administered as scheduled: acetaminophen 500 mg by mouth twice daily and daily as needed (PRN); Tolnaftate (antifungal) 1% powder topically twice daily to webbing space of toes;

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01820	Continued From page 72 aripiprazole (antipsychotic) 2 mg by mouth at bedtime; aspirin 81 mg by mouth daily; docusate sodium 100 mg, take two capsules by mouth twice daily; doxycycline 100 mg by mouth daily; ferrous sulfate 325 mg by mouth daily; Lasix 40 mg by mouth daily; Glucotrol 5 mg by mouth daily; hydrocodone-acetaminophen 5 mg/325 mg, take one half tablet by mouth twice daily; lisinopril 20 mg by mouth daily; metformin 1000 mg by mouth twice daily; multivitamin by mouth daily; Nuplazid 34 mg by mouth daily; MiraLAX 17 g in eight ounces of fluid by mouth daily; potassium chloride 20 mEq by mouth daily; and vitamin D3 25 mcg by mouth daily. During an interview on December 14, 2021, at 2:45 p.m., registered nurse (RN)-O confirmed orders for the above medications were not available, and she would contact the pharmacy to obtain orders. The licensee's 7.15 Medication & Treatment - Administration and Delegation policy dated August 1, 2021, noted prior to medication administration, the licensee must have current prescriber's orders on file. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.	01880		

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01880	Continued From page 73 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were securely stored for one of five residents (R1) with records reviewed and securely locked in medication carts to permit only authorized personnel had access. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: INVESTIGATION On December 8, 2021, at 10:20 a.m., the investigator observed medications unsecured in one of two unattended medication carts located in the hallway on the first floor. The medication cart's lock was popped out, indicating the cart was unlocked. The investigator was able to open all but one drawer in the medication cart, exposing many residents' medications and personal information. The investigator was unable to open a double-locked drawer, assuming it was the drawer containing narcotic medications. The investigator waited five minutes for a staff member to return, but no staff member arrived. The investigator locked the medication cart before proceeding with the building tour. On December 8, 2021, at 10:29 a.m., unlicensed	01880		

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01880	Continued From page 74 personnel (ULP)-D confirmed the medication carts are always expected to be locked when they are unattended by authorized staff. On December 8, 2021, at 10:30 a.m., ULP-E also confirmed that medication carts are to be locked any time the carts are unattended by staff. SURVEY On December 14, 2021, at 9:00 a.m., ULP-K entered R1's room to obtain a blood glucose (BG) level. R1 had a tackle box and in the tackle box was R1's insulin pens, including Levemir (long acting) and Novolog (short acting). The tackle box lock was located on the table, and the tackle box was unlocked. On December 16, 2021, at 11:30 a.m., registered nurse (RN)-A stated the licensee's policy was recently changed, and the insulin was not supposed to be in the tackle box. RN-V verified the insulin should be secured. The licensee's Medication & Treatments Medication Storage policy dated August 1, 2021, noted medications were to be kept securely locked in such a way to prevent diversion by residents or others. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription	01890		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01890	Continued From page 75 label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were labeled when opened for one of five residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 13, 2021, at 4:15 p.m., unlicensed personnel (ULP)-G assisted R1 with blood glucose monitoring (blood sugar levels). ULP-G pierced R1's finger, placed the strip in the machine, and reported a result of 381 (normal typically 60-120). R1's insulin pens were stored in a tackle box in R1's room, along with the blood glucose machine. The Levemir (long-acting) insulin pen and Novolog (short-acting) insulin pen were both open; however, the insulin pens lacked identification as to when they were opened. On December 13, 2021, at 4:15 p.m., ULP-G verified the insulin pens were not labeled when opened and stated the pens were supposed to be labeled when opened.	01890		

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01890	Continued From page 76 On December 16, 2021, at 11:30 a.m., registered nurse (RN)-A verified insulin pens should be labeled when opened. Manufacturer's instructions for Levemir noted to discard the opened insulin pen after 42 days. The Food and Drug Administration (FDA) recommends discarding opened insulin after 28 days. A policy and procedure regarding labeling insulin pens was requested, but not provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	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	01940		

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01940	Continued From page 77 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 interview and record review, the licensee failed to ensure individual treatment/therapy plans were developed for three of five residents (R1, R2 and R5) 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 prescriber orders dated December 7, 2021, included Mepilex (absorbent dressing) to open areas on coccyx, right upper thigh, right mid-thigh, and right lower thigh; replace Mondays, Thursdays and as needed.	01940		

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01940	Continued From page 78 R1's Treatment/Therapy Management plan dated August 30, 2021, lacked identification of treatment of pressure injuries including: -a written statement of the treatment or therapy services that will be provided to the resident; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel (ULPs); -procedures for notifying a registered nurse (RN) or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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 reaction. R2 R2's hospice (end of life services) notes dated December 8, 2021, noted "left little toe laceration: place triple antibiotic ointment on the toe and bandage daily or as needed. Hospice RN and/or facility staff to perform wound cares." R2's unsigned service plan dated December 14, 2021, indicated: -mechanical soft diet with nectar thick liquids -follow directions in electronic medication administration record (EMAR) for changing dressing to coccyx and left toe -addition of hospice services R2's Treatment/Therapy Management plan dated September 13, 2021, lacked identification of treatment of toe and mechanical soft diet including:	01940		

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01940	Continued From page 79 -a written statement of the treatment or therapy services that will be provided to the resident; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and -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 reaction On December 16, 2021, at 11:30 a.m., RN-A indicated treatment/therapy plans for R1 and R2 were completed on December 14, 2021. R5 R5's diagnoses included schizophrenia, Type II diabetes mellitus, delusional disorders, psychosis and alcohol dependence. R5's Treatment/Therapy Management Plan dated September 9, 2020, indicated R5 received blood glucose monitoring checks. R5's record lacked prescriber orders; however, R5's medication administration record (MAR) dated November 1, 2021, through December 14, 2021, indicated R5 received twice daily blood glucose monitoring checks. R5's service plan dated July 31, 2020, lacked a statement of services regarding R5's blood glucose monitoring checks.	01940		

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01940	Continued From page 80 On December 14, 2021, at 2:45 p.m., RN-O confirmed R5's service plan lacked services for blood glucose monitoring. The licensee's Treatment & Therapy Management Plan policy dated August 1, 2021, noted treatment and therapy plans were developed that included the required content. The treatment or therapy management record must be current and updated when there were any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=G	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950		

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01950	Continued From page 81 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel (ULP) in the proper method to perform treatment/therapies and failed to ensure the ULP demonstrated competency for two of two ULPs (ULP-H and ULP-L) who performed wound care, and two of two ULPs (ULP-F and K) who assisted with pressure injuries and repositioning. The licensee failed to ensure delegated treatment/therapy instructions were specified in writing for one of two residents (R2) with wound care reviewed. 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: ULP H, ULP-L, and R2 On December 14, 2021, at approximately 10:30 a.m., the surveyor observed ULP-H and ULP-L assisting R2 with morning cares. ULP-H and ULP-L stated R2 had a sore on her "pinky" toe. The surveyor observed Coban (self-adhesive wrap) wrapped around R2's left 5th toe. ULP-H and ULP-L stated they were instructed by the hospice nurse to apply antibiotic ointment and the	01950		

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01950	Continued From page 82 Coban to R2's left 5th toe. According to the ULPs, they had completed the dressing change yesterday. ULP-H had a hire date of August 13, 2021. ULP-H's training record lacked training and demonstration of competency for performing wound care. ULP-L had a hire date of August 30, 2021. ULP-L's training record lacked training and demonstration of competency for performing wound care. R2's unsigned and undated service plan included, "follow direction in electronic medication administration record (EMAR) for changing dressing to coccyx and left toe." R2's medication administration record (MAR) dated December 2021, included "apply bacitracin (antibiotic ointment used to prevent infection) to laceration on the left 5th toe and cover with bandage." R2's December 2021 MAR also noted, "Dressing change, apply barrier cream to coccyx and cover with Mepilex (absorbent dressing) dressing." Hospice (end of life service) visit notes dated December 14, 2021, noted, "Necrotic toe found. Orders not being followed." On December 15, 2021, at 10:30 a.m., RN-B verified the ULPs applied the bacitracin ointment and then wrapped R2's left 5th toe with Coban. RN-A and RN-B verified the treatment was incorrectly administered, which resulted in R2's necrotic toe. RN-A and RN-B verified ULPs were not trained for either treatment (to the toe and coccyx). RN-A and RN-B verified specific	01950		

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01950	Continued From page 83 directions were lacking regarding R2's treatments. ULP-F and ULP-K During the survey dated December 13, 2021, through December 17, 2021, the surveyor observed ULP-F and ULP-K providing care and assistance to R1. On December 13, 2021, at 4:15 p.m., the surveyor observed R1 lying in bed on her back. On December 13, 2021, at 5:45 p.m., the surveyor observed R1 lying in bed on her back. On December 13, 2021, at approximately 7:00 p.m., the surveyor observed R1 lying in bed on her back. ULP-F had a hire date of November 16, 2021. ULP-F's employee record lacked training on repositioning and pressure ulcers, including a basic under standing of off-loading and redistribution of tissue pressure (reduce or relieve the pressure on the area at risk, maintain general tissue integrity and ensure adequate blood supply to the at risk area). ULP-K had a hire date of August 30, 2021. ULP-K's employee record lacked training on repositioning and pressure ulcers, including a basic under standing of off-loading and redistribution of tissue pressure. R1's undated service plan directed ULPs to reposition R1 at 12:00 a.m., 3:00 a.m., 6:00 a.m., 9:30 a.m.,11:50 a.m., 2:00 p.m., 4:30 p.m., 7:00 p.m., and 10:00 p.m. R1's service plan noted, "She must offload whatever side she was laying on due to new onset of pressure ulcers."	01950		

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01950	Continued From page 84 R1's weekly wound record dated December 7, 2021, described R1 with "pressure ulcers" (a type of injury that breaks down the skin and underlying tissue when an area of skin is placed under constant pressure for certain period causing tissue ischemia). The areas included the following: -Right lateral hip stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer that measured 1 cm x 2 cm with depth of 0.1 -Right lateral thigh stage 2 pressure ulcer that measured 2 cm x 2.5 cm with depth of 0.1 -Coccyx stage 2 pressure ulcer "butterfly sore" with no description of measurements -Right lateral thigh stage 2 pressure ulcer that measured 6 cm x 7 cm with 0.1 depth. R1's weekly wound record dated December 9, 2021, noted the following: -Left buttock stage 2 "pressure ulcer" that measured 3 cm x 2 cm On December 15, 2021, at 10:00 a.m., the surveyor asked ULP-F how she repositioned R1. ULP-F stated R1 frequently lied near the edge of bed, and that she repositioned R1 when she was too close to the edge of bed so she did not fall out of bed. ULP-F stated R1 preferred to lie on her back or the right side. ULP-F stated she had not received training on repositioning residents with pressure injuries and verified a lack of understanding regarding off loading and/or pressure redistribution. On December 16, 2021 at 11:30 a.m., RN-A verified a lack of training for pressure ulcers and repositioning, and indicated staff training consisted of general skin condition and	01950		

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01950	Continued From page 85 discussions of increased redness. The licensee's Delegation of Assisted Living Services policy, dated June 2021, noted when the RN delegated tasks, they must ensure the person was properly trained and had demonstrated the ability to competently follow the procedures and perform the task. The licensee's Medication & Treatment Administration & Delegation policy dated August 2021, noted when a treatment was delegated, the RN must conduct a face-to-face assessment to determine what treatment will be provided and how that service will be provided. A RN must specify, in writing, specific instructions and document those in the resident's record. A RN must instruct the ULPs on the proper procedure and the ULPs must demonstrate their ability to competently follow the procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced	01970		

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01970	Continued From page 86 by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for two of five residents (R2 and R5) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2 During an observation on December 14, 2021, at approximately 10:30 a.m., unlicensed personnel (ULP)-H and ULP-L stated R2 had a sore on her "pinky" toe. The surveyor observed pink Coban (self-adhesive wrap) wrapped around R2's left 5th toe. ULP-H and ULP-L stated they were instructed by the hospice nurse to apply antibiotic ointment and the Coban. According to the ULPs, they completed R2's dressing change to the toe yesterday. R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services. R2's medication administration record (MAR) dated December 2021, included "apply bacitracin to laceration on the left 5th toe and cover with	01970		

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01970	Continued From page 87 bandage." R2's unsigned undated service plan directed ULPs to: "Follow direction in electronic medication administration record (EMAR) for dressing change to coccyx and left toe." R2's hospice notes, dated December 8, 2021, noted "left little toe laceration: place triple antibiotic ointment on the toe and bandage daily or as needed. Hospice registered nurse (RN) and/or facility staff to perform wound cares." R2's hospice notes, dated December 14, 2021, noted "Necrotic toe found. Orders not being followed." On December 15, 2021, at 10:30 a.m., RN-A and RN-B stated staff received orders to apply bacitracin and a bandage; however, the instructions did not specify the type of bandage. RN-A and RN-B verified the orders were not clear. RN-B stated the hospice nurse left Coban in the room, and ULPs wrapped the toe with Coban. R5 On December 14, 2021, at 7:15 a.m., ULP-E administered medications to R5 and offered to provide assistance with Juxtalight wraps (compression wraps), although R5 refused. R5's diagnoses included schizophrenia, Type II diabetes mellitus, delusional disorders, psychosis and alcohol dependence. R5's service plan dated July 31, 2020, indicated R5 received services including monitoring for signs and symptoms of auditory hallucinations, medication administration, Juxtalight wraps,	01970		

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01970	Continued From page 88 monthly vital signs and wound care. R5's MAR dated from November 1 through December 14, 2021, included daily wound monitoring, wound care every Monday, Wednesday and Friday and twice daily blood glucose monitoring. R5's prescriber orders dated November 9, 2021, included "Please add skin prep to wound care 3x (times) weekly," however, the orders did not include specific wound care instructions or orders for blood glucose monitoring. During an interview on December 14, 2021, at 2:45 p.m., RN-O confirmed orders for the above treatments lacked prescriber orders. RN-O stated R5 has skilled nursing who looks at his wound weekly. The licensee's Medication & Treatment Orders policy dated August 1, 2021, noted an order for a treatment must contain the name of the resident, a description of the treatment therapy to be provided and the frequency, duration and other information needed to carry out the order. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements:	02040		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 89 (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, 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). Findings include: A record review and interview were conducted on December 16, 2021, at approximately 10:45 a.m. with the Chief Executive Officer (CEO)-Q and the Director of Maintenance (DM)-R on the hazard vulnerability assessment for the physical environment of the facility. Record review indicated that the licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, CEO-Q stated that the licensee had not	02040		

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02040	Continued From page 90 performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02160 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (a) In addition to the minimum services required in section 144G.41, an assisted living facility with dementia care must also provide the following services: (1) assistance with activities of daily living that address the needs of each resident with dementia due to cognitive or physical limitations. These services must meet or be in addition to the requirements in the licensing rules for the facility. Services must be provided in a person-centered manner that promotes resident choice, dignity, and sustains the resident's abilities; (2) nonpharmacological practices that are person-centered and evidence-informed; (3) services to prepare and educate persons living with dementia and their legal and designated representatives about transitions in care and ensuring complete, timely communication between, across, and within settings; and (4) services that provide residents with choices for meaningful engagement with other facility residents and the broader community. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided in a person-centered manner that	02160		

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02160	Continued From page 91	02160		

promoted resident dignity for 10 of 27 residents (R1, R8, R9, R10, R11, R12, R14, R15, R16, and R18) who resided in the Assisted Living with Dementia Care unit.

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:

On December 13, 2021, at 5:30 p.m., unlicensed personnel (ULP)-F and ULP-G delivered dinner to residents who remained in their rooms. ULP-F and ULP-G used a cart to deliver the resident meals, which were in Styrofoam containers, Styrofoam beverage cups, and plastic eating utensils. The evening meal consisted of chicken chow mein, rice, and egg rolls. A list was posted in the dining room in the Assisted Living with Dementia Care unit, which identified 10 residents who received meals in their rooms: R1, R8, R9, R10, R11, R12, R14, R15, R16, and R18. In addition, there were two other residents identified with quotations "(offer dining room)." ULP-G stated the residents who remained in their rooms for meals were served in Styrofoam containers (along with plastic eating utensils).

On December 14, 2021, at 8:35 a.m., three residents sat in the dining room. ULPs served liquids in Styrofoam cups, and two residents were not provided any beverages. ULP-L stated meals

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02160	Continued From page 92 in rooms were typically served in Styrofoam containers, however, the kitchen was out of Styrofoam containers so residents who were served meals in their room received Styrofoam plates covered with plastic. ULP-L stated this was what dietary staff directed. On December 16, 2021, at 11:30 a.m., registered nurse (RN)-A verified she was unaware residents were served meals in Styrofoam containers. RN-A stated the use of plastic utensils was not a safety concern. RN-A stated residents in the ALFDC were not on intake and output, so their dietary intake was not assessed. RN-A verified some residents may object to their meals served in Styrofoam containers. RN-A verified the practice did not promote residents' dignity and may not be considered person-centered care. On December 16, 2021, at 4:15 p.m., certified food protection manager (CFPM)-S stated she assumed the use of Styrofoam containers was initiated because of COVID-19, when residents remained in their rooms. CFPM-S stated she was working with nursing to "figure out" who was not going to the dining room and why. CFPM-S stated the licensee did not have any trays to deliver meals. CFPM-S stated the licensee had ample plates and cups. The licensee's Food Service Policy dated July 25, 2021, noted temporary tray service may be provided to a resident following illness or injury. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02160		

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02170	Continued From page 93	02170		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	02170		

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02170	Continued From page 94 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individualized activity plan was developed for four of five residents (R2, R4, R5 and R6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), 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: R2 R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services. R2's record lacked an individualized activity plan with the required contents. R4 R4's diagnoses included Type II diabetes mellitus, pain, and Charcot's joint of the right ankle and foot (degenerative condition resulting in weakening of bones and soft tissues of the foot or ankle). R4's record included an individualized activity evaluation plan dated December 14, 2021. R5 R5's diagnoses included schizophrenia, Type II diabetes mellitus, delusional disorders, psychosis and alcohol dependence.	02170		

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02170	Continued From page 95 R5's record included an individualized activity evaluation plan dated December 14, 2021. R6 R6's diagnoses included bipolar disorder, Type II diabetes, depression and anxiety. R6's record included an individualized activity evaluation plan dated December 14, 2021. On December 14, 2021, at 12:15 p.m., registered nurse (RN)-A verified an individualized activity evaluation plan was not completed for R2. During an interview on December 15, 2021, at approximately 9:35 a.m., receptionist (R)-J confirmed she had completed R4, R5 and R6's individualized activity evaluation plans during the survey on December 14, 2021, and was directed to do so by executive director (ED)-P. The licensee's Activity Programming policy dated August 1, 2021, indicated the licensee provided a wide range of activities for residents. The policy lacked procedures regarding what was included in the evaluation for activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and	02180		

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02180	Continued From page 96 included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Access to secured outdoor space and walkways that allow residents to enter and return without staff assistance must be provided. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure behavioral symptoms negatively impacting the resident were included in the service plan or care plan, and staff initiated and coordinated outside consultation when indicated for one of two (R1) residents (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: On December 13, 2021, the surveyor observed R1 lying on her back in bed from at 4:15 p.m. to 7:00 p.m. R1's signed service plan dated July 30, 2021, lacked documentation of behavioral symptoms which negatively impacted R1 to include refusals for repositioning and toileting. R1's	02180		

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02180	Continued From page 97 documentation lacked evidence of outside coordination or consultation regarding the refusals of cares, in an attempt to increase R1's compliance. R1's Universal Assessment Tool dated December 7, 2021, included diagnoses of diabetes and dementia. R1's assessment described R1 as requiring full assistance with dressing, grooming, transferring, and bed mobility. R1 was described with "full incontinence" and required assistance with incontinence. R1's assessment noted behavioral symptoms which included resistive to cares/medications. R1's assessment included a Brief Interview for Mental Status (BIMS) dated March 30, 2020, with a score of 9, indicating moderate impairment. R1's progress notes dated November 19, 2021, noted the following: "Resident has large red areas with defined borders. Left hip measures 3.6 centimeters (cm) x 4 cm. Coccyx measures 8 cm x 7.5 cm in a butterfly shape. Right hip measures 7 cm x 8.8 cm. with 2 spots measuring 1 cm x 1 cm just superior to the large one. Slight serosanguinous (watery and pink) drainage to the coccyx wound. All wounds cleansed with wound cleaner and covered with Mepilex (absorbent dressing)." R1's weekly wound record dated December 7, 2021, described R1 with "pressure ulcers" (a type of injury that breaks down the skin and underlying tissue when an area of skin is placed under constant pressure for certain period causing tissue damage). The areas included the following: -Right lateral hip stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer that measured 1 cm x 2 cm with depth of 0.1	02180		

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02180	Continued From page 98 -Right lateral thigh stage 2 pressure ulcer that measured 2 cm x 2.5 cm with depth of 0.1 -Coccyx stage 2 pressure ulcer "butterfly sore" with no description of measurements -Right lateral thigh stage 2 pressure ulcer that measured 6 cm x 7 cm with 0.1 depth R1's weekly wound record dated December 9, 2021, noted the following: Left buttock stage 2 "pressure ulcer" that measured 3 cm x 2 cm On December 16, 2021, at 11:30 a.m., registered nurse (RN)-A and RN-B verified R1 had pressure injuries and stated R1 refused toileting and repositioning assistance. RN-A and RN-B verified a lack of interventions for staff to follow pertaining to R1's refusals of toileting and repositioning assistance. RN-B stated she instructed ULPs to report refusals of repositioning and toileting. RN-A reported the Associated Clinic of Psychology (ACP) provider visited the licensee and stated "it might be worth a try" for R1's refusals. RN-B indicated R1 may have been seen by ACP and stated she would check for any visit notes or recommendations. The licensee's Assisted Living Dementia Care Behavioral Symptoms, Interventions & Nonpharmacological Approaches policy dated August 1, 2021, noted the licensee would identify behavioral symptoms that negatively impacted other residents and others in the assisted living and evaluate to determine potential interventions to minimize such behaviors. Interventions will be identified on the care plan or service plan. Behavioral symptoms that require outside consultation will be identified and acted upon. No further information was provided.	02180		

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02180	Continued From page 99 TIME PERIOD FOR CORRECTION: Seven (7) days	02180		
02310 SS=G	144G.91 Subd. 4 Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure assisted living services were provided based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards for one of one resident (R2) with a toe injury, and one of one resident (R1) with multiple pressure injuries. 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: R2 R2's medical record included diagnoses of dementia and anorexia. R2 was identified as receiving hospice (end of life) services.	02310		

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02310	Continued From page 100 R2's Universal Assessment Tool, dated December 2, 2021, noted R2 required assistance with dressing and grooming. R2's assessment noted memory loss, inability to understand others, and word-finding difficulty. R2's pain assessment, dated September 13, 2021, described the client's body language (related to pain) as "fidgeting." R2's medication administration record (MAR), dated December 2021, included "apply bacitracin (antibiotic ointment used to prevent infection) to laceration on the left 5th toe and cover with bandage." Progress notes, dated December 8, 2021, noted "Hospice nurse trimmed toe nails today and cut the 5th toe on the left foot. Order for bacitracin to toe until healed." Hospice orders, dated December 2, 2021, included morphine (a narcotic pain medication) 5 milligrams (mg) four times a day. Hospice notes, dated December 8, 2021, noted "left little toe laceration: place triple antibiotic ointment on the toe and bandage daily or as needed. Hospice RN (registered nurse) and/or facility staff to perform wound cares." Hospice visit notes, dated December 14, 2021, noted "Necrotic [the death of most or all of the cells in an organ or tissue due to disease, injury, or failure of the blood supply] toe found. Orders not being followed." During an observation on December 13, 2021, at 4:30 p.m., unlicensed personnel (ULP)-F and	02310		

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02310	Continued From page 101 ULP-G assisted R2 from the bed to wheelchair. During the transfer, R2 was crying out "ow" and moaning. ULP-F and ULP-G reported R2 had pain, and this was not uncommon. During an observation on December 14, 2021, at approximately 10:30 a.m., the surveyor heard R2 crying in her room from the hall area. Upon entering R2's room, the surveyor observed ULP-L and ULP-H assisting R2 with morning cares. ULP-L and ULP-H reported R2 was in pain, and had received morphine at 8:00 a.m. The surveyor observed a roll of Coban (self-adhesive wrap) and a foam dressing on R2's dresser. When questioned, ULP-L and ULP-H stated R2 had a sore on her "pinky" toe. The surveyor observed the Coban wrapped around R2's left 5th toe. ULP-L and ULP-H stated they were instructed by the hospice nurse to apply antibiotic ointment and the Coban. According to the ULPs, they had completed the dressing change yesterday. On December 15, 2021, at approximately 10:00 a.m., R2's family member (FM-I) was visiting R2. ULP-F reported R2's toe was infected. The surveyor entered R2's room and FM-I questioned if the surveyor had seen R2's toe. FM-I described the toe as "awful" and stated R2 was in pain. On December 15, 2021, at 10:30 a.m., Registered Nurse (RN)-A and RN-B were interviewed. RN-B verified R2's toe lacked an assessment with a description of the injury. RN-B verified the only documentation was dated on December 8, 2021. RN-B verified ULP applied the bacitracin ointment and then wrapped R2's left 5th toe with Coban. RN-A and RN-B verified the treatment was incorrectly administered. RN-B verified specific directions for the treatment was lacking and that she was unaware the ULPs	02310		

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02310	Continued From page 102	02310		

wrapped the toe with Coban. RN-A and RN-B verified staff were not supposed to use Coban but were instructed by the hospice nurse to wrap it with Coban. RN-B verified a pain assessment for R2 was lacking. RN-A and RN-B verified a lack of training for the ULP's for the specific treatment. RN-A and RN-B stated they were informed by hospice on December 14, 2021, of R2's toe's condition.

A picture of R2's toe, dated December 14, 2021, was reviewed. The left 5th toe was red and purple with a large, intact fluid filled blister on dorsal (upper) side of toe above the toenail. The toenail was intact, and was dusky blue/black in color. The distal (left) side of toe, adjacent to toenail, was red with several small petechiae-like (small pinpoint sized round spots) blisters around the edges of toenail. The distal edge of toenail had scant oozing blood and/or serosanguinous fluid (yellowish fluid with small amounts of blood). The plantar (bottom) side of toe had an intact fluid filled blister.

The licensee's Medication & Treatment Administration & Delegation policy, dated August 2021, noted when a treatment was delegated, the registered nurse (RN) must conduct a face-to-face assessment to determine what treatment will be provided and how that service will be provided. A RN must specify in writing, specific instructions and document those in the resident's record. A RN must instruct the ULP on the proper procedure and the ULP must demonstrate their ability to competently follow the procedure.

The licensee's Resident Change in Condition or Need policy, dated June 2021, noted initial reviews and scheduled assessments and

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02310	Continued From page 103 monitoring were completed as required. The licensee's Uniform Assessment Tool policy, dated June 2021, noted pain, including location, frequency, intensity, and duration was completed as part of the assessment. The policy noted skin conditions were assessed. R1 On December 13, 2021, the surveyor observed R1 lying on her back in bed from at 4:15 p.m. to 7:00 p.m. During the observation, R1 engaged in conversations, and interacted with staff and the surveyor. On December 16, 2021, at 10:30 a.m., before a shower, R1 refused to allow the surveyor to view her skin condition, including the multiple pressure ulcers. R1's Universal Assessment Tool, dated December 7, 2021, included diagnoses of diabetes and dementia. The assessment described R1 as requiring full assistance with dressing, grooming, transferring, and assistance with bed mobility. R1 was described with "full incontinence" and required assistance with incontinence care. The assessment noted behavioral symptoms which included resistive to cares/medications. The assessment included a Brief Interview for Mental Status (BIMS), dated March 30, 2020, with a score of 9, indicating moderate impairment. R1's Service Checkoff List (documentation of services provided by ULPs), dated December 2021, directed ULPs to reposition and toilet R1 at 12:00 a.m., 3:00 a.m., 6:00 a.m., 9:30 a.m., 11:50 a.m., 2:00 p.m., 4:30 p.m., 7:00 p.m., and 10:00 p.m., each day.	02310		

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02310	Continued From page 104 R1's progress notes, dated November 19, 2021, noted the following: "Resident has large red areas with defined borders. Left hip measures 3.6 centimeters (cm) x 4 cm. Coccyx measures 8 cm x 7.5 cm in a butterfly shape. Right hip measures 7 cm x 8.8 cm. with two spots measuring 1 cm x 1 cm just superior to the large one. Slight serosanguinous (watery and pink) drainage to the coccyx wound. All wounds cleansed with wound cleaner and covered with Mepilex (an absorbent dressing)." R1's record lacked any further documentation of the wounds, including any assessments or treatments provided until December 7, 2021, (or 18 days later). R1's record included documentation of referrals to outsourced agencies for skilled nursing on December 2, and 6, 2021. Documentation noted the outsourced agencies were unable to provide assistance with wound care. Prescriber orders, dated December 7, 2021, included Mepilex to open areas on coccyx, right upper thigh, right mid-thigh, and right lower thigh. Replace Mondays, Thursdays and as needed. R1's weekly wound record, dated December 7, 2021, described R1 with "pressure ulcers" (a type of injury that breaks down the skin and underlying tissue when an area of skin is placed under constant pressure for certain period causing tissue damage). The areas included the following: -Right lateral hip stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer that measured 1 cm x 2 cm with depth of 0.1 -Right lateral thigh stage 2 pressure ulcer that	02310		

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02310	Continued From page 105 measured 2 cm x 2.5 cm with depth of 0.1 -Coccyx stage 2 pressure ulcer "butterfly sore" with no description of measurements -Right lateral thigh stage 2 pressure ulcer that measured 6 cm x 7 cm with 0.1 depth R1's weekly wound record, dated December 9, 2021, noted the following: -Left buttock stage 2 "pressure ulcer" that measured 3 cm x 2 cm R1's wound record documentation, dated December 16, 2021, included the following: -Left buttock stage one (persistent area of redness) 3 cm x 2 cm -Right lateral thigh stage one, 1.5 cm x 3 cm -Right lateral thigh stage one 8 cm x 8 cm -Right lateral thigh stage one 1 cm x 1 cm -Coccyx stage one 6 cm x 6 cm On December 15, 2021, at 10:00 a.m., ULP-F stated R1 frequently lied near the edge of bed, and that she repositioned R1 when she was too close to the edge of bed, so she did not fall out of bed. ULP-F stated R1 preferred to lie on her back, or the right side. ULP-F stated she did not receive training on repositioning residents with pressure injuries. ULP-F verified a lack of understanding regarding off loading and/or pressure redistribution (reduce or relieve the pressure on the area at risk, maintain general tissue integrity and ensure adequate blood supply to the at risk area). On December 16, 2021, at 11:30 a.m., RN-A and RN-B verified R1 had pressure injuries and refused toileting and repositioning assistance. RN-A and RN-B verified R1's refusals of repositioning and toileting assistance lacked interventions for staff to follow regarding R1's	02310		

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02310	Continued From page 106	02310		

refusals. RN-A and RN-B verified the lack of a pressure relieving device on the bed, despite the resident's refusals to reposition. RN-A verified the initial pressure areas were identified on November 19, 2021, and there was a lack of assessments and treatments until December 7, 2021. RN-A indicated this was because the licensee did not provide wound care, and outsourced agencies were contacted, but unable to provide wound care. RN-A and RN-B stated R1 was able to make slight changes in repositioning. RN-B stated she instructed ULPs to report any refusals including repositioning and toileting. RN-A verified a lack of training for pressure ulcers and repositioning, and indicated training consisted of general skin condition and discussions of increased redness.

The licensee's Delegation of Assisted Living Services policy, dated June 2021, noted when the RN delegated tasks, they must ensure the person was properly trained and had demonstrated the ability to competently follow the procedures and perform the task.

The licensee's Resident Change in Condition or Need policy, dated June 2021, noted initial reviews and scheduled assessments and monitoring were completed as required.

The licensee's Uniform Disclosure of Assisted Living Services and Amenities, dated August 1, 2021, noted the licensee provided basic wound care services.

A policy and procedure regarding pressure ulcers was requested, but not provided.

TIME PERIOD FOR CORRECTION: IMMEDIATE

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02310	Continued From page 107 Immediacy is removed as confirmed by supervisor's communication with licensee on December 16, 2021, however noncompliance remains at a scope and severity of G. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		
03000 SS=D	626.557 Subd. 3 Timing of report (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement	03000		

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03000	Continued From page 108 agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of five residents (R2) with records reviewed. In addition, the licensee failed to implement the facility's written procedures pertaining to allegations of resident maltreatment for one of five residents (R2) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	03000		

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03000	Continued From page 109 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's medical record included diagnoses of dementia and anorexia (loss of appetite). R2 was identified as receiving hospice (end of life) services. R2's Universal Assessment Tool dated December 2, 2021, noted R2 required assistance with dressing and grooming. R2's assessment noted R2 had memory loss, inability to understand others, and word-finding difficulty. R2's pain assessment dated September 13, 2021, described the R2's body language (related to pain) as "fidgeting." R2's hospice (end of life service) orders dated December 2, 2021, included morphine (a narcotic pain medication) 5 milligrams (mg) four times a day. ALLEGATION OF NEGLECT On December 14, 2021, at 1:15 p.m., family member (FM)-I reported to the surveyor she assisted R2 with personal cares "last Friday night" including assisting with pajamas (December 3, 2021). FM-I stated she returned to the licensee on Saturday at 2:30 p.m. (December 4, 2021). FM-I stated R2 had not been cared for since FM-I left the licensee on December 3, 2021. FM-I stated R2 was still in the pajamas she was dressed in on December 3, 2021. FM-I stated R2's incontinence pad was "loaded" with urine and stool. FM-I stated she was upset, and immediately sought assistance from unlicensed personnel (ULP)-M. FM-I indicated at the time,	03000		

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03000	Continued From page 110	03000		

she was not provided with any answers regarding R2's apparent lack of care assistance. FM-I stated she reported the incident to executive director (ED)-P and registered nurse (RN)-A on Monday December 6, 2021. FM-I stated ED-P and RN-A stated they would "look into" the incident.

A review of the staffing schedule for December 4, 2021, from 6:30 a.m. to 2:30 p.m., indicated there were two ULPs working. The RN was also on-call.

During the entrance conference on December 13, 2021, at 11:00 a.m., ED-P and RN-A indicated the unit where R2 resided was staffed with three ULPs during the day and evening shifts, and RN-B Monday-Friday, 8:00 a.m. to 4:30 p.m.

During an interview on December 14, 2021, at 2:00 p.m., ED-P and RN-A indicted R2 had an unwitnessed fall (another incident) and mentioned an additional incident regarding a staff member who "falsified" R2's medication record and was sleeping on the job (see below allegation of staff member). ED-P and RN-A verified the incident was not reported to MAARC. RN-A stated she spoke with the ULPs that worked on December 4, 2021. The ULPs reported personal cares were provided to R2. RN-A stated she did not have any documentation of the investigation. RN-A verified she was unable to provide the dates and times of individuals who were interviewed, including ULP-M, who assisted R2 after FM-I sought assistance on December 4, 2021. RN-A and ED-P verified the licensee had cameras in the memory care unit, and they had the capability to view when and who entered R2's room, including how long they were in the room. RN-A and ED-P verified they had not viewed the

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footage. RN-A stated FM-I was offered a complaint form, and FM-I did not want to complete the form. RN-A indicated FM-I's reluctance to complete a compliant form, was the reason why the allegation was not called into MAARC, and why the incident was not investigated. RN-A and ED-P stated the allegation by FM-I was considered abuse and neglect. The surveyor directed the licensee to report the incident to MAARC.

ALLEGATION OF STAFF MEMBER
A Medication Incident Report dated December 5, 2021, noted R2's morphine (narcotic analgesic) 5 milligrams (mg) was not administered on December 5, 2021, at 8:00 a.m. and 12:00 p.m. The narrative noted: "Both 8:00 a.m. and 12:00 p.m. doses were documented given at 1:07 p.m. Neither dose was popped out of the bubble card or signed out in narc [narcotic book] book." The corrective action noted "write-up."

On December 14, 2021, at 2:00 p.m., ED-P and RN-A indicated an employee was sleeping on the job December 5, 2021, and that R2's morphine was not administered as directed. RN-A indicated R2's medication administration record (MAR) was falsified, indicating the morphine was administered. ED-P and RN-A reported the employee was terminated. ED-P and RN-A did not respond when the surveyor asked if there was a possibly there were other residents in similar situations, or if other residents did not receive cares or medications as directed.

On December 15, 2021, at 10:30 a.m., RN-A verified R2's morphine omission, allegation of an employee sleeping on the job, and the employee's subsequent termination were not reported to MAARC. The surveyor directed the

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03000	Continued From page 112 licensee to report the incident to MAARC. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy dated August 1, 2021, defined maltreatment as neglect, abuse and exploitation. The policy noted the director of nursing and ED were responsible for investigating and reporting incidents (no later than 24 hours after the maltreatment was first suspected) any incident of suspected maltreatment. The investigation will begin as soon as a report is received. As part of the internal investigation, the director of nursing and ED will: - interview witnesses or persons who may have information concerning the incident - document the witness statements concerning the incidents - review the resident's care plan and relevant chart records and agency policies - review the witness statements, resident records, resident's individual abuse protection plan, and agency policies to determine whether abuse, neglect has occurred, including standards of care, that may have been violated No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03000		
03030 SS=D	626.557 Subd. (4,a) Internal reporting of maltreatment (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a	03030		

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03030	Continued From page 113 mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. (b) A facility with an internal reporting procedure that receives an internal report by a mandated reporter shall give the mandated reporter a written notice stating whether the facility has reported the incident to the common entry point. The written notice must be provided within two working days and in a manner that protects the confidentiality of the reporter. (c) The written response to the mandated reporter shall note that if the mandated reporter is not satisfied with the action taken by the facility on whether to report the incident to the common entry point, then the mandated reporter may report externally. (d) A facility may not prohibit a mandated reporter from reporting externally, and a facility is prohibited from retaliating against a mandated reporter who reports an incident to the common entry point in good faith. The written notice by the facility must inform the mandated reporter of this protection from retaliatory measures by the facility against the mandated reporter for reporting externally. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment and complete a thorough investigation for one of five residents (R2) with records reviewed. In addition, the licensee failed to implement their written procedures pertaining to allegations of maltreatment for one of five residents (R2) with records reviewed.	03030		

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03030	Continued From page 114 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R2's medical record included diagnoses of dementia and anorexia (loss of appetite). R2 was identified as receiving hospice (end of life) services. R2's Universal Assessment Tool dated December 2, 2021, noted R2 required assistance with dressing and grooming. R2's assessment noted R2 had memory loss, inability to understand others, and word-finding difficulty. R2's pain assessment dated September 13, 2021, described R2's body language (related to pain) as "fidgeting." R2's hospice (end of life service) orders dated December 2, 2021, included morphine (a narcotic pain medication) 5 milligrams (mg) four times a day. ALLEGATION OF NEGLECT On December 14, 2021, at 1:15 p.m., family member (FM)-I reported to the surveyor she assisted R2 with personal cares "last Friday night" including assisting with pajamas (December 3, 2021). FM-I stated she returned to the licensee on Saturday at 2:30 p.m. (December	03030		

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03030	Continued From page 115	03030		

4, 2021). FM-I stated R2 had not been cared for since FM-I left the licensee on December 3, 2021. FM-I stated R2 was still in the pajamas she was dressed in on December 3, 2021. FM-I stated R2's incontinence pad was "loaded" with urine and stool. FM-I stated she was upset, and immediately sought assistance from unlicensed personnel (ULP)-M. FM-I indicated at the time, she was not provided with any answers regarding R2's apparent lack of care assistance. FM-I stated she reported the incident to executive director (ED)-P and registered nurse (RN)-A on Monday December 6, 2021. FM-I stated ED-P and RN-A stated they would "look into" the incident.

A review of the staffing schedule for December 4, 2021, from 6:30 a.m. to 2:30 p.m., indicated there were two ULPs working. The RN was also on-call.

During the entrance conference on December 13, 2021, at 11:00 a.m., ED-P and RN-A indicated the unit where R2 resided was staffed with three ULPs during the day and evening shifts, and RN-B Monday-Friday, 8:00 a.m. to 4:30 p.m.

During an interview on December 14, 2021, at 2:00 p.m., ED-P and RN-A indicted R2 had an unwitnessed fall (another incident) and mentioned an additional incident regarding a staff member who "falsified" R2's medication record and was sleeping on the job (see below allegation of staff member). ED-P and RN-A verified the incident was not reported to MAARC. RN-A stated she spoke with the ULPs that worked on December 4, 2021. The ULPs reported personal cares were provided to R2. RN-A stated she did not have any documentation of the investigation. RN-A verified she was unable to provide the dates and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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
03030	Continued From page 116	03030		

times of individuals who were interviewed, including ULP-M, who assisted R2 after FM-I sought assistance on December 4, 2021. RN-A and ED-P verified the licensee had cameras in the memory care unit, and they had the capability to view when and who entered R2's room, including how long they were in the room. RN-A and ED-P verified they had not viewed the footage. RN-A stated FM-I was offered a complaint form, and FM-I did not want to complete the form. RN-A indicated FM-I's reluctance to complete a compliant form, was the reason why the allegation was not called into MAARC, and why the incident was not investigated. RN-A and ED-P stated the allegation by FM-I was considered abuse and neglect. The surveyor directed the licensee to report the incident to MAARC.

ALLEGATION OF STAFF MEMBER
A Medication Incident Report dated December 5, 2021, noted R2's morphine (narcotic analgesic), 5 milligrams (mg) was not administered on December 5, 2021, at 8:00 a.m. and 12:00 p.m. The narrative noted: "Both 8:00 a.m. and 12:00 p.m. doses were documented given at 1:07 p.m. Neither dose was popped out of the bubble card or signed out in narc [narcotic book] book." The corrective action noted "write-up."

On December 14, 2021, at 2:00 p.m., ED-P and RN-A indicated an employee was sleeping on the job December 5, 2021, and that R2's morphine was not administered as directed. RN-A indicated R2's medication administration record (MAR) was falsified, indicating the morphine was administered. ED-P and RN-A reported the employee was terminated. ED-P and RN-A did not respond when the surveyor asked if there were possibly other residents in similar situations,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31968	A. BUILDING: _____ B. WING _____	12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HILL SENIOR LIVING LLC	3030 SOUTHLAWN DRIVE MAPLEWOOD, MN 55109

(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
03030	Continued From page 117 or if other residents did not receive cares or medications as directed. On December 15, 2021, at 10:30 a.m., RN-A verified R2's morphine omission, allegation of an employee sleeping on the job, and the employee's subsequent termination were not reported to MAARC. The surveyor directed the licensee to report the incident to MAARC. The licensee's Vulnerable Adult Maltreatment-Prevention & Reporting policy, dated August 1, 2021, defined maltreatment as neglect, abuse and exploitation. The policy noted the director of nursing and ED were responsible for investigating and reporting incidents (no later than 24 hours after the maltreatment was first suspected) any incident of suspected maltreatment. The investigation will begin as soon as a report is received. As part of the internal investigation, the director of nursing and ED will: - interview witnesses or persons who may have information concerning the incident - document the witness statements concerning the incidents - review the resident's care plan and relevant chart records and agency policies - review the witness statements, resident records, resident's individual abuse protection plan, and agency policies to determine whether abuse, neglect has occurred, including standards of care, that may have been violated No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03030		

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

Type: Full
Date: *12/14/21*
Time: 10:00:00
Report: 8059211076

Food and Beverage Establishment Inspection Report

Location:
Maple Hill Senior Living Llc
3030 Southlawn Drive
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0038951
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6513633690
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.

2-300 Personal Cleanliness

2-301.14A ** Priority 1 **

MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.

EMPLOYEES IN MEMORY CARE DID NOT WASH HANDS BEFORE PUTTING ON GLOVES FOR FOOD SERVICE. EMPLOYEES WERE ASKED TO TAKE GLOVES OFF AND WASH HANDS.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

MN Rule 4626.0840A Equipment food-contact surfaces and utensils must be clean to sight and touch.

CAN OPENER HAD A BUILD-UP OF FOOD DEBRIS. CLEAN CAN OPENER AFTER EACH USE.

Comply By: 12/14/21

2-400 Hygenic Practices

2-402.11

MN Rule 4626.0115 Food employees must wear an effective hair restraint, such as a hat, hair covering or hair net, a beard restraint and clothing to keep hair from contacting exposed food, clean equipment, utensils, linens, and unwrapped single-service or single-use articles.

FOOD EMPLOYEE IN MAIN KITCHEN DID NOT HAVE HAIR RESTRAINT ON. EMPLOYEE PUT HAIR RESTRAINT ON. EMPLOYEE IN MEMORY CARE DID NOT WERE A HAIR NET WHEN PREPARING FOOD FOR PATIENTS. ALL EMPLOYEES THAT HANDLE AND PREPARE FOOD NEED TO HAVE A HAIR RESTRAINT ON.

Comply By: 12/14/21

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14D

MN Rule 4626.0285D Provide an approved sanitizing solution for storage of the wet wiping cloths that is free of food debris and visible soil.

WET WIPING CLOTHS WERE BEING STORED IN SANITIZER THAT MEASURED AT 0PPM QUAT. MANAGER REMADE SANITIZER BUCKET AND IT WAS MEASURED AT 300PPM QUAT.

Corrected on Site

4-600 Cleaning Equipment and Utensils

4-601.11C

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

INTERNAL BOTTOM OF TOASTER IN MEMORY CARE KITCHEN HAD A BUILD-UP OF FOOD DEBRIS. CLEAN AND MAINTAIN CLEAN.

Comply By: 12/17/21

4-900 Protecting Clean Items

4-904.11C

MN Rule 4626.0965C Provide and use proper dispensers or the intact original individual wrapper for consumer self-service of straws, lids, single-service cups, and other single-service articles intended for food or lip contact.

SELF-SERVICE STRAWS WERE NOT INDIVIDUALLY WRAPPED OR USING A PROPER DISPENSER. FOLLOW RULE ABOVE.

Comply By: 12/21/21

5-500 Refuse and Recyclables

5-501.17

MN Rule 4626.1260 Provide covered receptacles in the toilet room for sanitary napkins or diapers.

TRASH BINS IN THE EMPLOYEE BATHROOMS DID NOT HAVE A COVER ON THEM.

Comply By: 12/21/21

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

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

WALL AND CEILING IN DRY-STORAGE HAVE FOOD DEBRIS SPLASHED ON. CLEAN AND MAINTAIN.

Comply By: 12/17/21

Surface and Equipment Sanitizers

Quaternary Ammonia: = 300ppm at 80 Degrees Fahrenheit
Location: Remade sani bucket on cook line
Violation Issued: No

Hot Water: = at 170 Degrees Fahrenheit
Location: Dishwasher
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Hot Hold/Potato
Temperature: 155 Degrees Fahrenheit - Location: Hot holding on oven
Violation Issued: No

Process/Item: Hot Hold/Hamburger
Temperature: 190 Degrees Fahrenheit - Location: Steam well
Violation Issued: No

Process/Item: Cook Temp/Egg
Temperature: 180 Degrees Fahrenheit - Location: Cooked for hot holding
Violation Issued: No

Process/Item: Cold Hold/Egg Salad
Temperature: 38 Degrees Fahrenheit - Location: Reach-in Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Cream
Temperature: 39 Degrees Fahrenheit - Location: Under counter refrigerator in service area
Violation Issued: No

Process/Item: Cold Hold/Egg
Temperature: 38 Degrees Fahrenheit - Location: Self-service refrigerator in service area
Violation Issued: No

Process/Item: Cold Hold/Rice
Temperature: 39 Degrees Fahrenheit - Location: Walk-in Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Egg Roll
Temperature: 37 Degrees Fahrenheit - Location: Walk-in Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Ambient
Temperature: 34 Degrees Fahrenheit - Location: Walk-in Refrigerator
Violation Issued: No

Process/Item: Cold Hold/Milk
Temperature: 40 Degrees Fahrenheit - Location: Memory Care Refrigerator
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	1	6

All violations were discussed with Culinary Director Nataja and lead evaluator Tracy Pouti.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 8059211076 of 12/14/21.

Certified Food Protection Manager: Nataja Nelson

Certification Number: 45308 Expires: 08/12/23

Signed: _____

Nataja Nelson
Culinary Director

Signed: _____

James Noyola
Sanitarian Supervisor
St. Paul
651-201-4500
health.foodlodging@state.mn.us