Electronically Delivered

November 13, 2024

Licensee
Maple House LLC
5900 Ambassador Boulevard Northwest
Saint Francis, MN 55070

RE: Project Number(s) SL34178015

Dear Licensee:

On September 24, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 10, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

Benjamin J. Zwart, P.E., Supervisor
State Engineering Services Section
Health Regulation Division
Email: Benjamin.Zwart@state.mn.us
Telephone: 651-201-3715 Fax: 1-866-890-9290

JMD

Electronically Delivered

August 1, 2024

Licensee
Maple House LLC
5900 Ambassador Boulevard Northwest
Saint Francis, MN 55070

RE: Project Number(s) SL34178015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 10, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Kelly Thorson

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34178	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HOUSE LLC	5900 AMBASSADOR BOULEVARD NW SAINT FRANCIS, MN 55070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL34178015 On July 8, 2024, through, July 10, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were five residents; five receiving services under the provider's Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated July 8, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 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	0 660		

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0 660	Continued From page 2 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 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 licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-C). 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: The facility's TB risk assessment was completed on October 17, 2023, and the facility was determined to be a low risk level. ULP-C was hired on July 10, 2023, to provide	0 660		

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0 660	Continued From page 3 direct care services to residents at the assisted living facility. On July 9, 2024, at 9:30 a.m., the surveyor observed ULP-C provide scheduled morning medication administration to R2. ULP-C's employee record lacked evidence of required Baseline Screening Tool for Healthcare Personnel and completion of a two-step TST or other evidence of TB screening such as a blood test. On July 9, 2024, at 11:20 a.m., clinical nurse supervisor (CNS)-A stated ULP-C did not complete the screening tool or the tuberculin skin testing. CNS-A stated, "the supplies for testing were ordered, but I (CNS-A) forgot to do it (administer the TST) and it was overlooked." On July 9, 2024, at 11:25 a.m., ULP-C stated that ULP-C was aware of the requirement, however, forgot that the screening tool and the tuberculin skin test needed to be completed because they (facility) were waiting for testing supplies. The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated baseline TB screening at the time of hire is required for all HCWs (healthcare workers) in Minnesota. Baseline TB screening consists of three components: (1) assessing for current symptoms of active TB disease, (2) assessing TB history, and 3) TB testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single TB blood test. The Minnesota Department of Health guidelines Regulations for Tuberculosis Control in Minnesota	0 660		

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0 660	Continued From page 4 Health Care Settings dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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 temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not	0 680		

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0 680	Continued From page 5 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 develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include: The licensee's EPP dated October, 31, 2023, lacked documentation including all the required elements of: - EPP resident population; - subsistence needs for staff and residents during an emergency to include (food, water, medical supplies, pharmacy supplies, sewer and waste disposal, emergency lighting, fire detection, extinguishing and alarm systems;- procedures for tracking of staff and patients; - policies and procedures for sheltering in place; - emergency staffing strategies to include volunteers; - the facilities role in providing care and treatment	0 680		

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0 680	Continued From page 6 at alternative sites under a 1135 waiver; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On July 9, 2024, at 2:00 p.m., clinical nurse supervisor (CNS)-A stated CNS-A had updated the EPP several times, however, was unaware that it may be missing some of the required information. The licensee's Emergency Preparedness policy dated October 31, 2023 indicated [the facility] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 770 SS=F	144G.45 Subdivision 1 Minimum site Requirements The following are required for all assisted living facilities: (1) public utilities must be available, and working or inspected and approved water and septic systems must be in place; (2) the location must be publicly accessible to fire department services and emergency medical services; (3) the location's topography must provide sufficient natural drainage and is not subject to flooding; (4) all-weather roads and walks must be provided	0 770		

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0 770	Continued From page 7 within the lot lines to the primary entrance and the service entrance, including employees' and visitors' parking at the site; and (5) the location must include space for outdoor activities for residents. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain the drinking water supply. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, at 1:00 p.m. survey staff toured the facility with maintenance (M)-F and clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the water supply for the facility was provided by a private well. Survey staff requested a copy of the most recent well water test. The well water report dated August 31, 2023, indicated the well water tested positive for coliform bacteria. Coliform bacteria are not a normal inhabitant of groundwater and their presence indicates a potential pathway for contamination to enter the drinking water supply. During the facility tour interview, CNS-A stated they did not know if the well water had been disinfected and retested after the facility received the coliform bacteria positive test result from	0 770		

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0 770	Continued From page 8 August 2023. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 770		
0 790 SS=E	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain one portable fire extinguisher as required by statute. This deficient condition had the potential to affect more than a limited 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 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	0 790		

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0 790	Continued From page 9 pervasive). The findings include: On July 10, 2024, at 1:00 p.m. survey staff toured the facility with maintenance (M)-F and clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the annual maintenance inspection tag attached to the portable fire extinguisher installed in the basement laundry/mechanical room was dated 2019. Annual maintenance inspections performed by certified service personnel are required for each portable fire extinguisher. During the facility tour interview, CNS-A verified an annual maintenance inspection had not been completed and stated they did not realize a fire extinguisher was installed in this location. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a	0 800		

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0 800	Continued From page 10 continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, at 1:00 p.m. survey staff toured the facility with maintenance (M)-F and clinical nurse supervisor (CNS)-A. During the tour, survey staff observed the following: 1. An inspection tag or report were not available for the fire sprinkler system indicating an inspection had been completed in the last year. Annual inspections of automatic fire sprinkler systems are required to ensure the system's proper functionality and compliance. During the facility tour interview, M-F stated an inspection had not been completed on the sprinkler system in the last year. 2. In occupied resident bedroom 2, an exterior door opened leading to a deck enclosed by railings with a stair lift. This door was labeled as an emergency exit on the posted floor plan. During the facility tour interview, M-F stated they did not know if the stair lift worked and thought it required a key to operate. The stair lift was not demonstrated to be operable during the tour. 3. The dining room exterior door opened leading to a deck enclosed by railings, with no stairs. This door was labeled as an emergency exit on the	0 800		

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0 800	Continued From page 11 posted floor plan. All paths of egress must provide unobstructed exiting. During an interview on July 10, 2024, at 3:00 p.m., CNS-A stated the doors were improperly labeled as exits leading to both enclosed decks. 4. In occupied resident bedroom 2, a desk and personal belongings obstructed the egress window. The improper placement of furniture and personal items could delay exiting in the event of an emergency. During the facility tour interview, M-F and CNS-A verified the egress window was obstructed. 5. A door handle/knob was missing from the laundry/mechanical room door. During the facility tour interview, CNS-A stated a door knob needed to be installed. 6. In occupied resident bedroom 4: a. The flooring and base trim had been removed, the cement floor was exposed. b. The wall was unfinished around the door leading to the exterior of the home from the bedroom. 7. In occupied resident bedroom 5: a. There was a hole in the ceiling above the bathtub in the bathroom. b. There was a hole in the ceiling in the bedroom closet. During the facility tour interview, M-F and CNS-A verified these floor, wall, and ceiling surfaces required repair. 8. In the main floor bathroom near the front entrance, the sink faucet was loose, and a plastic tub had been placed under the sink to catch dripping water. The vanity base was water damaged and several areas were stained black. During the facility tour interview, M-F stated the sink faucet and vanity required repair.	0 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 800	Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34178	A. BUILDING: _____ B. WING _____	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HOUSE LLC	5900 AMBASSADOR BOULEVARD NW SAINT FRANCIS, MN 55070

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to develop fire safety and evacuation plans with the required content, and provide required training and drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 10, 2024, clinical nurse supervisor (CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN Record review of the available documentation indicated the licensee failed to develop and maintain the FSEP. Accurate FSEP floor plans were not developed. Emergency evacuation floor plans were included with the facility FSEP in the emergency binder. On July 10, 2024, at 1:00 p.m. survey staff toured the facility with maintenance (M)-F and CNS-A. During the tour, survey staff observed the emergency exits labeled on the floor plans posted in the facility did not match the FSEP floor plans	0 810		

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0 810	Continued From page 14 in the emergency binder. Accurate emergency evacuation floor plans are required to provide efficient communication for exiting in the event of a fire or similar emergency. During an interview at 2:55 p.m., CNS-A verified the floor plans did not match and stated these plans would be revised. The FSEP referenced smoke compartments, but these compartments were not identified on the floor plans or in the written procedures for evacuation. The FSEP referenced pull fire alarms, but pull fire alarms were not observed during the facility tour. During an interview on July 10, 2024, at 3:00 p.m., CNS-A verified an accurate FSEP had not been developed and stated revisions were required. TRAINING Record review indicated that the licensee failed to provide training to employees on the FSEP upon hire and/or at least twice per year as evident by the lack of training documentation. An annual FSEP training record for employees dated April 17, 2024, was provided for review. During an interview on July 10, 2024, at 2:55 p.m., LALD-E stated new hire employees completed fire safety training as part of the emergency preparedness training from a third-party online training provider. CNS-A verified training records were not available to support employee training on the FSEP had been completed at the frequency required by statute. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by fire drill reports lacking the required frequency. Four employee fire drills were recorded in 2023. Three drills were	0 810		

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	34178	A. BUILDING: _____ B. WING _____	07/10/2024

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0 810	Continued From page 15 conducted in February and one in October. Five employee fire drills were recorded in 2024. Three drills were conducted in January, one in April, and one in June. The time or shift of the drill was not recorded on the fire drill logs dated April 17, 2024, and June 17, 2024. During an interview on July 10, 2024, at 2:55 p.m., CNS-A, verified the employee evacuation drill frequency was not met and employee names needed to be recorded on all drill records. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan.	01640		

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01640	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on July 8, 2024 at 10:30 a.m., clinical nurse supervisor (CNS)-A stated the licensee was aware of minimum assisted living regulations. R1 was admitted to the assisted living facility on October 23, 2023. R1's Service Plan dated October 26, 2023, indicated R1 received services including medication administration. R1's record included a self-administration of medication order dated February 8, 2024. R1's service plan lacked revision to reflect R1 no longer received medication administration. On July 9, 2024, at 9:00 a.m., CNS-A stated CNS-A did not revise R1's service plan after R1	01640		

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01640	Continued From page 17 requested to no longer receive medication administration. CNS-A further stated the licensee was aware service plans needed to be revised when residents services change. The licensee's Service Plan policy dated August 1, 2021, indicated the service plan must be revised, if needed, based on resident review or reassessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
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 by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for one of two residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01710		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01710	Continued From page 18 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 was admitted to the assisted living facility on October 23, 2023. R1's diagnoses included opioid disorder, generalized anxiety disorder, post-traumatic stress disorder (PTSD), and attention deficit hyperactivity disorder (ADHD). R1's signed service plan dated October 26, 2023, indicated R1 received services to include medication administration, medication reminder, behavior management and housekeeping. R1's record indicated R1 stopped receiving medication administration on February 13, 2024. R1's medication assessment dated April 26, 2024, indicated registered nurse / licensed practical nurse to manage medications, home health aide staff to administer, resident ok to self-administer Victoza (antidiabetic medication injection) with staff supervision. On July 9, 2024, at 9:00 a.m., clinical nurse supervisor (CNS)-A stated CNS-A was aware a reassessment was required, however, CNS-A had not completed the reassessment. CNS-A stated "I (CNS-A) missed that, that's on me. I (CNS-A) was training a new employee and didn't finish the assessment or update the service agreement". The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated ongoing	01710		

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01710	Continued From page 19 resident reassessments must be conducted by an RN and cannot exceed 90 days from the last date of assessment. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		
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 ensure medications were maintained bearing legible information including the opened-on date for time sensitive medication for one of four residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include:	01890		

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01890	Continued From page 20 During the entrance conference on July 8, 2024, at 10:30a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to residents at the facility. On July 9, 2024, at 8:45 a.m., the surveyor reviewed the medication cabinet with unlicensed personnel (ULP)-C and observed R2's Miconazole Nitrate 2% ointment was not labeled with an opened date or expiration date. On July 9, 2024, at 12:35 p.m., ULP-C stated ULP-C was not aware that an open date needed to be written on the label. ULP-C further stated that ULP-C writes open dates on insulin, however, did not know that it was required for creams or salves. On July 9, 2024, at 12:50 p.m., CNS-A stated CNS-A was aware of this requirement, however, had not reviewed medications to verify it was being done. The licensee's Storage/Control of Medications policy dated October 31, 2023, indicated the licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul
6512014500

Type: Full
Date: *07/08/24*
Time: 12:40:53
Report: 1029241200

Food and Beverage Establishment Inspection Report

Location:
Maple House Llc
5900 Ambassador Boulevard Nw
St Francis, MN55070
Anoka County, 02

Establishment Info:
ID #: 0038887
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 7636076874
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.

2-200 Employee Health

2-201.11C ***** Priority 1 *****

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

EMPLOYEE ILLNESS LOG NOT PRESENT. ILLNESS LOG PRINTED DURING INSPECTION. EMPLOYEE ILLNESS DOCUMENTATION AND REPORTING PROCEDURES DISCUSSED.

Comply By: 07/08/24

3-100 Food Characteristics: unadulterated

3-101.11 ***** Priority 1 *****

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

BUTTER HELD AT ROOM TEMPERATURE FOR GREATER THAN 6 HOURS W/OUT TPHC. DISCARDED BY ESTABLISHMENT. ALTERNATIVES DISCUSSED.

Comply By: 07/08/24

3-500C Microbial Control: date marking

3-501.17B ***** Priority 2 *****

MN Rule 4626.0400B Mark the refrigerated, ready-to-eat, TCS food prepared and packaged in a processing plant and opened and held for more than 24 hours in the food establishment using an effective method to indicate the date by which the food must be consumed on the premises, sold, or discarded. The date must not exceed the manufacturer's use-by-date.

DATE MARKINGS ABSENT FROM DELI MEATS. CORRECTED DURING INSPECTION. DATE MARKING DISCUSSED.

Comply By: 07/08/24

Type: Full
Date: *07/08/24*
Time: 12:40:53
Report: 1029241200
Maple House Llc

Food and Beverage Establishment Inspection Report

Surface and Equipment Sanitizers

QUATERNARY AMMONIUM: = 300 PPM at Degrees Fahrenheit
Location: SANITIZER SOLUTION
Violation Issued: No

Food and Equipment Temperatures

Process/Item: SLICED TURKEY
Temperature: 40 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: SLICED HAM
Temperature: 41 Degrees Fahrenheit - Location: REFRIGERATOR
Violation Issued: No

Process/Item: MILK
Temperature: 36 Degrees Fahrenheit - Location: SMALLER REFRIGERATOR
Violation Issued: No

Process/Item: BUTTER
Temperature: 73 Degrees Fahrenheit - Location: AMBIENT FOR GREATER THAN 6 HOURS
Violation Issued: Yes

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

Establishment uses NSF 184 dishwasher to sanitize equipment and utensils. Thermal stickers used to verify minimum high temperatures of 160°F.

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 1029241200 of 07/08/24.

Certified Food Protection Manager: MELISSA K. KOOP

Certification Number: FM118896 Expires: 09/15/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
MELISSA KOOP
RN

Signed: *Trevor McCliment*
Trevor McCliment
Public Health Sanitarian
Metro District Office
651-201-3957
trevor.mccliment@state.mn.us

Report #: 1029241200

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools, and Lodging Services
625 Robert Street North
St. Paul

No. of RF/PHI Categories Out	3	Date	07/08/24
No. of Repeat RF/PHI Categories Out	0	Time In	12:40:53
Legal Authority MN Rules Chapter 4626		Time Out	

Maple House Llc	Address: 5900 Ambassador Boulevard Nw	City/State: St Francis, MN	Zip Code: 55070	Telephone: 7636076874
License/Permit #: 0038887	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Supervision			
1	(IN) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN (OUT)	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT (N/O)	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	IN (OUT)	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A (N/O)	Proper cooking time & temperature		
19	IN OUT N/A (N/O)	Proper reheating procedures for hot holding		
20	IN OUT N/A (N/O)	Proper cooling time & temperature		
21	IN OUT N/A (N/O)	Proper hot holding temperatures		
22	(IN) OUT N/A	Proper cold holding temperatures		
23	IN (OUT) N/A N/O	Proper date marking & disposition		
24	IN OUT (N/A) N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT (N/A)	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	(IN) OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT (N/A)	Food additives: approved & properly used		
28	(IN) OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT (N/A)	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT (N/A)	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) MKeek **Date:** 07/08/24

Inspector (Signature) *Trevor McCliment*