



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 29, 2024

Licensee
Maple Care Homes
1209 East 131st Street
Burnsville, MN 55337

RE: Project Number(s) SL33376015

Dear Licensee:

On April 11, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on January 23, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the January 23, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on January 23, 2024, found not corrected at the time of the April 11, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0810-Fire Protection And Physical Environment-144g.45 Subd. 2 (b)-(f) - \$500.00

The details of the violations noted at the time of this follow-up survey completed on April 11, 2024 (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 approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

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 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.

A state correction 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.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

We urge you to review these orders carefully. If you have questions, please contact Robert Dehler at 651-201-3710.

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

Sincerely,



Bob Dehler, P.E.
Engineering Manager
Engineering Services Section
Health Regulation Division
Email: Robert.Dehler@state.mn.us
Telephone: 651-201-3710

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33376	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 04/11/2024
NAME OF PROVIDER OR SUPPLIER MAPLE CARE HOMES		STREET ADDRESS, CITY, STATE, ZIP CODE 1209 EAST 131ST STREET BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 000}	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: SL33376015-1 On April 11, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on January 23, 2024. At the time of the survey, there were 3 residents; 3 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued.	{0 000}			
{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;	{0 680}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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{0 680}	Continued From page 1 (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 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: No further action required.	{0 680}			
{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	{0 810}			

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{0 810}	Continued From page 2 thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content. 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: During observation on April 11, 2024, at 10:00 a.m., the surveyor observed the fire evacuation diagrams did not include room numbers for each resident bedroom. Evacuation plans shall include	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 3 the location and number of resident sleeping rooms. On April 11, 2024, unlicensed personnel (ULP)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility to survey staff. FIRE SAFETY AND EVACUATION PLAN The licensee's FSEP, titled "Fire Policy", dated 8/01/2021, failed to include the following: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The provided FSEP was from a third-party provider and had not been updated to the specific facility. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During interview on April 11, 2024, at 11:00 a.m., ULP-A stated she did not know anything about	{0 810}			

Minnesota Department of Health

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{0 810}	Continued From page 4 the policy or how to update it. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. ULP-A was unable to provide documentation showing any training offered to residents on the fire safety and evacuation plan. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. ULP-A was unable to provide documentation showing any training provided to employees on the fire safety and evacuation plan. During an interview on April 11, 2024, at 11:00 a.m., ULP-A stated she did not remember receiving any training on the fire safety and evacuation plans. 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. Provided documentation did not include a log for the fire drills. During an interview on April 11, 2024, at 11:00 a.m., ULP-A stated she did not remember completing any fire drills. No further information was provided.	{0 810}			
{0 950} SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	{0 950}			

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{0 950}	Continued From page 5 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: No further action required.	{0 950}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or	{0 970}			

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{0 970}	Continued From page 6 unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: No further action required.	{0 970}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 14, 2024

Licensee
Maple Care Homes
1209 East 131st Street
Burnsville, MN 55337

RE: Project Number(s) SL33376015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 23, 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>

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,

A handwritten signature in cursive script that reads "Renee L. Anderson".

Renee Anderson, Supervisor

State Evaluation Team

Email: renee.anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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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: SL33376015-0 On January 22, 2024, through January 23, 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 four residents, all who received services under the assisted living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.		
0 680 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	0 680			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 680	Continued From page 1 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 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 disaster plan with all required content. This had the potential to affect all four residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 680			

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0 680	Continued From page 2 The findings include: The licensee's emergency preparedness plan was reviewed on January 24, 2024, and lacked the following content: -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -development of policies for handling and use of volunteers; and -annual EP testing requirements. On January 23, 2024, at 10:20 a.m., administrative assistant (AA)-D stated she had been working on completing and understanding the requirements for the emergency plan for all of the licensee facilities, and verified the above was missing from the emergency plan. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated the licensee 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 additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code;	0 790			

Minnesota Department of Health

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0 790	Continued From page 3 (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 fire extinguishers in accordance with MN Statute. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On January 22, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. It was observed that the portable fire extinguishers were tagged showing the last required annual service date was January 2022. The fire extinguishers also lacked the records to show the required monthly visual inspections to date. During interview, survey staff explained to LALD-A that the portable fire extinguishers must	0 790			

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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
0 790	Continued From page 4 be provided annual certification tags and also monthly visual inspection or "quick checks" of each extinguisher by a staff member to ensure all portable extinguishers are readily available, fully charged, and operable at their designated location with no obvious physical damage or condition to the extinguisher that would prevent their operation when needed. LALD-A verified the findings and stated that he understood the requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
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.	0 810			

Minnesota Department of Health

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0 810	Continued From page 5 (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 the fire safety and evacuation plan with the required content and provide the 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: During a phone call on January 22, 2024, at 10:30 a.m. survey staff requested the fire safety and evacuation plan (FSEP) from the licensed assisted living director/ licensed practical nurse (LALD)-A.	0 810			

Minnesota Department of Health

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0 810	Continued From page 6 On January 22, 2024, at 11:24 a.m. survey staff emailed LALD-A requesting the FSEP documentation for review and to set up a time to go over the FSEP with LALD-A, but did not receive a reply. On January 23, 2024, at 3:45 p.m. survey staff emailed LALD-A again to request the FSEP documentation for review, but did not receive a reply. In the email survey staff informed LALD-A that the 0810 tag would be issued if the FSEP documentation was not received. On January 24, 2023, at 5:00 p.m. no records had been received for the FSEP, training, and drills. No further information was provided.	0 810			
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820			

Minnesota Department of Health

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0 820	Continued From page 7 Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. 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, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 22, 2024, at 10:30 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the tour, survey staff asked LALD-A to open the windows in unoccupied resident bedrooms #1 - #4 for measurement. The measurements were as follows: Temporarily Unoccupied Sleeping Rooms: Bedroom #1: one window measuring 42.5 inches clear width, 18 inches clear height, and 765 square inches total open area. Bedroom #2: one window measuring 42.5 inches clear width, 18 inches clear height, and 765 square inches total open area. Bedroom #3: one window measuring 42.5 inches clear width, 18 inches clear height, and 765 square inches total open area. Bedroom #4: one window measuring 24 inches clear width, 43.5 inches clear height, and 1,044	0 820			

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0 820	Continued From page 8 square inches total open area. The windows in bedrooms #1, #2, and #3 did not meet the minimum requirements for opening height. Survey staff explained to LALD-A that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. During an interview on January 22, 2024, LALD-A stated they had a fire in the lower level bedroom and temporarily relocated all their residents to a different facility. LALD-A stated they were planning to move the residents back into the facility during the same week the survey was taking place. Survey staff recommended the residents not move back into the facility until the non-compliant windows in bedrooms #1, #2, and #3 were corrected. LALD-A stated he was not sure if the residents could stay at the temporary facility that much longer and all the residents were eager to return. Survey staff explained to LALD-A that he would need to implement a fire watch policy starting on the day the residents moved back in and continue the fire watch until the windows were corrected. LALD-A stated he understood the requirement and would ensure a fire watch was implemented if he decided to move the residents back into the facility before the windows in bedrooms #1, #2, and #3 were	0 820			

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0 820	Continued From page 9 corrected. No Further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 820			
0 950 SS=F	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative.	0 950			

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0 950	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to offer the resident the opportunity to identify a designated representative in writing for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: The licensee's assisted living contract lacked the required language that offers the resident the opportunity to name a designated representative in writing in the contract. R1 R1's service plan dated November 1, 2021, indicated R1 received services to include medication administration, laundry, and housekeeping. On January 23, 2024, at 10:20 a.m., licensed assisted living director (LALD)-A stated R1's contract lacked the required designated representative language and lacked documentation to indicate they declined to name a representative. LALD-A stated residents are offered opportunity to name a representative during admission, but verified the contract lacked the required designated representative language.	0 950			

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0 950	Continued From page 11 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the facility's liability for resident health, safety, or personal property of a resident or indemnification language waving liability for any damage or injury to the resident or any other person or property occurring on the licensee premises. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).	0 970			

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0 970	Continued From page 12 The findings include: On January 22, 2024, during the entrance conference at 10:00 a.m., the surveyor requested a blank copy of the licensee's contract. The licensee's Assisted Living Contract included a section for Liability that read, "The resident agrees to be liable and responsible for all obligations herein referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced". The contract included a section for Indemnification that read, the licensee "shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, or any part thereof, or in common areas thereof, and the resident agrees to hold [the licensee] harmless from any claims or damages unless caused solely by negligence of [the licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident." On January 23, 2024, at 10:20 a.m., administrative assistant (AA)-D stated the licensee's assisted living contract included the above content, and she was in the process of rewriting the current contract for the licensee. AA-D stated the same contract was provided to all residents at the facility.	0 970			

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0 970	Continued From page 13 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			



Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 01/23/24
Time: 09:46:46
Report: 8044241024

Food and Beverage Establishment Inspection Report

Page 1

Location:

Maple Care Homes
1209 E 131st St
Burnsville, MN 55429
Dakota County, 19

Establishment Info:

ID #: 0042365
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #:
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.

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

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

HRD inspection conducted with Nurse Evaluator, Jolene Bertlsen. Report reviewed on site with Director Ayo Awolaye.

Establishment kitchen consists of residential equipment, hot water sanitizing dishwasher, vinyl flooring, wooden hollow base cabinets, and painted gypsum walls and ceiling.

Establishment recently had a fire, no food or clients were on premises.

Type: Full
Date: 01/23/24
Time: 09:46:46
Report: 8044241024
Maple Care Homes

Food and Beverage Establishment Inspection Report

Page 2

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

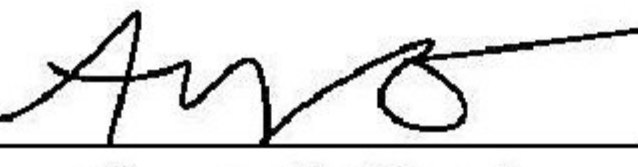
I acknowledge receipt of the Minnesota Department of Health inspection report number 8044241024 of 01/23/24.

Certified Food Protection Manager Cameo S. Anderson

Certification Number: FM108935 Expires: 12/06/24

Signed: 
Inspector signed for Ayo

Signed: 
Michael DeMars, RS
Public Health Sanitarian III
Rochester District Office
507-216-1096
michael.demars@state.mn.us

Report #: 8044241024		Food Establishment Inspection Report					
 Minnesota Department of Health Division of Environmental Health, FPLS P.O. Box 64975 St. Paul, MN 55164-0975		No. of RF/PHI Categories Out		0		Date 01/23/24	
		No. of Repeat RF/PHI Categories Out		0		Time In 09:46:46	
		Legal Authority MN Rules Chapter 4626				Time Out	
Maple Care Homes		Address 1209 E 131st St		City/State Burnsville, MN		Zip Code 55429	
Telephone		License/Permit # 0042365		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 Hygienic 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 procedure 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			
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							
COS				R			
Safe Food and Water							
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 labeled; 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			
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 procedures 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.							
Proper Use of Utensils							
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) 							
Date: 01/24/24							
Inspector (Signature) 							