DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 3, 2023

Licensee
The Homestead At Maplewood
1890 Sherren Avenue East
Maplewood, MN 55109

RE: Project Number(s) SL20712015

Dear Licensee:

On April 21, 2023, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the February 27, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

PMB

Electronically Delivered

March 24, 2023

Licensee
The Homestead At Maplewood
1890 Sherren Avenue East
Maplewood, MN 55109

RE: Project Number(s) SL20712015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on February 27, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

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

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

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

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

The total amount you are assessed is $3,000.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

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

Please address your cover letter for reconsideration requests to:

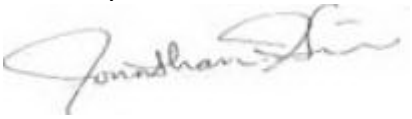
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to: **Health.HRD.Appeals@state.mn.us**.

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

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

Sincerely,



Jonathan Hill, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-3993 Fax: 651-281-9796

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20712	A. BUILDING: _____ B. WING _____	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT MAPLEWOOD	1890 SHERREN AVENUE EAST MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******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: SL20712015 On February 21, 2023, through February 27, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 44 residents receiving services under the Assisted Living/ Dementia Care license. An immediate correction order was identified on February 21, 2023, at 6:43 p.m., and issued for tag identification 2310. On February 22, 2023, at 3:45 p.m., the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	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 with Dementia Care licensed providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level pursuant to 144G.31 Subd. 1, 2 and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (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 according to the Minnesota Food Code. This had the potential to affect the licensee's 44 current 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 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: Please refer to the additional documentation included in the "Food and Beverage Establishment Inspection Reports," dated February 22, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	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	0 660		

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0 660	Continued From page 2 tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide 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 interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC). The licensee failed to ensure screening for active TB (either a two-step tuberculin skin test (TST) or blood test) was completed and documented for two of two employees (registered nurse (RN)-F, unlicensed personal (ULP)-E). 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 tuberculosis (TB) risk assessment	0 660		

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0 660	Continued From page 3 dated June 10, 2021, indicated the facility was a low risk setting for TB transmission. RN-F RN-F was hired July 11, 2022, and provided direct cares for residents of the facility. RN-F's employee record included a TB symptom screening form completed June 13, 2022. RN-F's screening form included negative results of a single TST test administered June 13, 2022, and read on June 15, 2022. RN-F employee record lacked a second step TST. ULP-E ULP-E was hired September 12, 2022, and provided direct cares for residents of the facility. ULP-E's employee record included a TB screening form completed August 30, 2022, which included a negative result of a single TST test administered August 30, 2022, and read on September 2, 2022. ULP-E's employee record lacked a second step TST. On February 22, 2023, at 12:32 p.m., during an interview, director of nursing (DON)-B stated RN-F did not have a second step mantoux. DON-B stated she was not sure why this was missed and stated RN-F should have had a second step TST upon hire. On February 23, 2023 the second step TST for ULP-E was requested from licensed assisted living director (LALD)-A. LALD-A provided a document entitled Employee Health Screening	0 660		

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0 660	Continued From page 4 Form which verified a second step TST was not completed. The Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, noted, "The purpose of this manual is to assist health care facilities in Minnesota to understand what is needed to be in compliance with Minnesota laws revised in 2013 regarding TB prevention and control, and to provide tools for implementing legal regulations and best practices in their settings." This included, Baseline TB screening is required for all health care workers (HCW). Baseline TB screening consists of three components: 1. Assessing for current symptoms of active TB disease; 2. Assessing TB history; 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step TST or single IGRA; and An employee may begin working with patients after a negative TB symptom screen (i.e., no symptoms of active TB disease) and a negative IGRA or TST (i.e., frst step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients." The Tuberculosis Screening, Testing and Treatment of U.S. Health Care Personnel: Recommendations from the National Tuberculosis Controllers Association and Centers for Disease Control and Prevention, dated May 17, 2019, indicated "TB screening is defined as a process that includes a TB risk assessment, symptom evaluation and TB testing for Mycobacterium tuberculosis infection (by either	0 660		

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0 660	Continued From page 5 IGRS or TST) for health care personnel without documented evidence of prior LTBI or TB disease and additional workup for TB disease for health care personnel with positive results or symptoms compatible with TB disease." In addition, "All U.S., healthcare personnel should have a baseline TB screening, including am individual risk assessment, which is necessary for interpreting any test result." The licensee's Tuberculosis screening policy dated 2020, indicated, "The Centers for Disease Control and Prevention (CDC) and the National TB Controllers Association (NTCA) recommend that all U.S. health care personnel be screened for TB upon hire (i.e., pre-placement). Pre-placement screening should include a TB risk assessment, including a TB symptom screen, and a TB test. It is the policy of this facility (unless otherwise indicated by State requirements) to follow the CDC recommendations for health care personnel screening. In addition, 1. TB screening with an individual risk assessment and symptom evaluation at hire (preplacement). 2. TB testing with an interferon-gamma release assay (IGRA) or a tuberculin skin test (TST)." The Centers for Disease Control and Prevention (CDC), dated August 30, 2022, indicated that "all United States (U.S.). health care personnel should be screened for TB upon hire. The local health department should be notified immediately if TB disease is suspected". No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		

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0 780	Continued From page 6	0 780		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms in each room used for sleeping purposes. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 780		

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0 780	Continued From page 7 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 February 23, 2023, between 11:00 a.m. and 12:30 p.m., survey staff toured the facility with maintenance (M)-D. During the facility tour, survey staff observed that smoke alarms were not installed in the sleeping rooms of resident apartments 114, 310, and 315. This deficient condition was visually verified by M-D accompanying on the facility tour. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique	0 810		

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0 810	Continued From page 8 or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to document the required employee evacuation drills. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include:	0 810		

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0 810	Continued From page 9 On February 23, 2023, at approximately 12:30 p.m., records were provided for review. Records were reviewed by survey staff on February 23, 2023, between 12:30 p.m. and 1:15 p.m. Record review of documented evacuation drills indicated that evacuation drills for employees had not been completed at a frequency of every other month. Evacuation drills were recorded for January, February, April, May, July, October, and November in 2022. No evacuation drill records were provided for 2023. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On January 18, 2023, at approximately 1:30 p.m., the licensed assisted living director (LALD)-A verified this deficient condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01540 SS=D	144G.64 (a) TRAINING IN DEMENTIA CARE REQUIRED (3) for assisted living facilities with dementia care, direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource	01540		

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01540	Continued From page 10 and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received the required amount of dementia care training in the required time frame for two of two employees, unlicensed personnel (ULP)-E and registered nurse (RN)-F. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a 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 licensee had a current assisted living facility with dementia care (ALFDC) license effective August 1, 2021. ULP-E was hired September 12, 2022, and was observed to provide direct cares to residents of the facility. ULP-E's training and orientation records indicated six hours of dementia care training completed	01540		

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	20712	A. BUILDING: _____ B. WING _____	02/27/2023

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01540	Continued From page 11 between September 21, 2022, and September 28, 2022. ULP-E's employee record lacked evidence of eight hours of initial training on topics related to dementia care. On February 23, 2023, at 4:06 p.m.(via email) licensed assisted living director (LALD) confirmed ULP-E was lacking two hours of dementia care training and stated two hours had been added to her Relias training schedule. RN-F was hired July 11, 2022, and provided direct cares to residents of the facility. RN-F's training and orientation records indicated six hours of dementia care training completed between July 14, 2022, and July 18, 2022. RN-F's employee record lacked evidence of at least eight hours of initial training on topics related to dementia care. On February 22, 2023, at 12:32 p.m., director of nursing (DON)-B stated RN-F only had six hours of dementia care training and it was possible human resources (HR) could have documentation for in-person courses, and they would check with their off-site HR contact. As of the exit for the survey February 27, 2023, no additional documentation was provided. The licensee's education policy dated as revised May 3, 2016, did not include required dementia education requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Fourteen (14) days	01540		

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01620	Continued From page 12	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure the registered nurse (RN) completed a required comprehensive reassessment no later than 14 days after initiation of services, for two of four residents (R3, R4). 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	01620		

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01620	Continued From page 13 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: R3 was admitted September 1, 2022, and had diagnoses to include diabetes, chronic kidney disease (CKD), and depression. R3's service plan dated September 3, 2022, indicated R3 received services including assistance with transfers, activities of daily living (ADLs), toileting, wound care, blood glucose (BG) monitoring, and medication management. R3's record included an undated, hand-written assessment, and an initial assessment dated September 7, 2022. R3's record further included a comprehensive nursing assessment dated December 2, 2022. On February 22, 2023, at 11:47 p.m., director of nursing (DON)-B stated the hand-written baseline pre-assessment was completed August 26, 2022, and the admission assessment was the assessment completed September 7, 2022. DON-B stated a 14-day reassessment was not completed for R3. R4 was admitted November 7, 2022, and had diagnoses to include Alzheimer's disease and Chronic Kidney Disease (CKD). R4's service plan, dated November 10, 2022, indicated R4 received services including assistance with bathing, dressing, grooming, blood glucose monitoring and medication management.	01620		

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01620	Continued From page 14 R4's record included documentation of a pre-admission assessment and an admission comprehensive nursing assessment completed November 4, 2022 and November 10, 2022, respectively. R4's medical record lacked a 14 day post admission comprehensive assessment. Additionally, R4's subsequent comprehensive nursing assessment, dated February 15, 2023, exceeded 90 days from the previous assessment. On February 22, 2023, at 10:50 a.m., registered nurse (RN)-B stated that R4's 14-day assessment was not completed and 90 day assessment was overdue. RN-B indicated that "she was instructed when a pre-admission assessment was completed that a 14 day assessment was not required." The licensee's Initial and On-Going Nursing Assessment of Clients (residents) policy dated March 2018, included language from Home Care (144A) which indicated, "An RN will complete a nursing assessment of each Comprehensive home care client (assisted living resident) within five days of the initiation of home care services, and prior to the initiation of nursing or delegated nursing services or therapy or assigned therapy services. The assessment will be the basis for the service plan/Care Plan that the RN will recommend to the client and the basis for the service plan/Care Plan that staff will follow when implementing the client's services. The RN will reassess the client and update the service plan/Care Plan based on the client's needs within 14 days of admission and then at a frequency not to exceed 90 days from the last date of the assessment. The RN will review the nursing assessment and service plan/Care Plan and, if necessary, will update the assessment and service plan/Care Plan, whenever the client has	01620		

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01620	Continued From page 15 returned from a hospital or nursing home stay, has a change in condition or experiences an incident such as a fall." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure medications were administered as prescribed for two of four residents (R3, R4). 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	01760		

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01760	Continued From page 16 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: R3's diagnoses included type 2 diabetes. R3's service plan dated September 5, 2022, indicated R3 received services including assistance with medication management. R3's record included prescriber orders, signed January 11, 2023, indicating: -acetaminophen tablet (for pain) 325 milligrams (mg), take three tablets (975 mg) by mouth three times daily; -gabapentin capsule (for pain) 100 mg, take one capsule by mouth two times daily; R3's record included additional prescriber orders, signed February 1, 2023, indicating: -Debrox (Carbamide Peroxide, for earwax buildup), five drops to both ears for six days; and -Senna S (Sennosides-Docusate Sodium-for constipation), one tablet by mouth two times daily; -insulin aspart (a fast acting insulin, for diabetes) 100 units per milliliter (u/ml), inject 5 u subcutaneously three times daily before meals; and -pravastatin (for cholesterol) 40 mg, take one tablet by mouth daily at bedtime. R3's medication administration record (MAR) from February 1 to February 22, 2023, lacked documentation of administration, or why the following were not administered: -Debrox otic solution: February 4 at 6:00-10:00 p.m.; -pravastalin sodium tablet: February 4, 10-11, and 18 at 6:00-10:00 p.m.;	01760		

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01760	Continued From page 17 -gabapentin capsule: February 4, 10-11, and 18 at 6:00-10:00 p.m.; -Senna Plus tablet: February 4, 10-11, and 18 at 6:00-10:00 p.m.; -acetaminophen tablet: February 4 at 3:00-6:00 p.m., February 10-11, and 18 at 6:00-10:00 p.m.; and -insulin aspart solution: February 11 at 6:00 a.m. and 11:00 a.m., and February 14-15 at 6:00 a.m. R4 R4's diagnoses included Alzheimer's disease, chronic kidney disease, and type two diabetes mellitus. R4's service plan dated November 10, 2022, indicated R4 received services including assistance with medication administration. R4's record included a prescriber order signed November 7, 2022, indicating Admelog SoloStar (short-acting insulin) solution pen-injector, 100 u/ml, ten units subcutaneous three times per day, and Lantus SoloStar (long-acting insulin) pen-injector 100 u/ml, inject 40 units subcutaneous one time per day. On February 21, 2023, at 4:00 p.m., surveyor observed unlicensed personnel (ULP)-G, administer Admelog (short-acting insulin) to R4 according to the provider orders. R4's medication administration record MAR from February 1 to February 22, 2023, lacked documentation of administration, or why the following were not administered: - Admelog SoloStar insulin: February 11, 8:00 a.m., 12:00 p.m.; and February 17, 12:00 p.m.; - Lantus SoloStar insulin: February 17, 6:15 a.m. On February 23, 2023, at 5:15 p.m., DON-B stated (via email) no additional documentation was available. DON-B further stated medications	01760		

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01760	Continued From page 18 not administered should be documented NC (not completed), or could also be documented as, leave of absence (LOA) with medications, drug refused, vital sign out of parameter, sleeping, spit out medications, or out of building, and would be reported to the nurse. The licensee's Medication Management Services policy, dated March 11, 2022, indicated "The Director of Health Care Services will determine which medication management services our Assisted Living will offer. The RN is responsible for the implementation of our Assisted Living's medication management policies and procedures, with the assistance, when appropriate, of a consulting pharmacist. Based on the nursing assessment, the RN will develop an individualized medication management plan for each resident receiving any type of medication management services, consistent with current practice standards and guidelines, and will develop specific procedures for medication management services that staff will provide. The RN will assure that unlicensed personnel are trained, competent and oriented to the resident whenever unlicensed personnel are to perform medication management services for the resident. Additionally, documentation of medication management activities, including if needed, medication set up." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by	01910		

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01910	Continued From page 19 the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on observation, and interview, the licensee failed to dispose of expired medications, including documenting the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals in the disposition, for one of four residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01910		

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01910	Continued From page 20 The findings include: On February 21, 2023, at 2:48 p.m., during an observation of resident medication bins and stock medication storage area with registered nurse (RN)-F, the following were observed: In R3's medication bin: -pravastatin (cholesterol) 40 milligrams (mg); expired December 1, 2022; -natures bounty vitamin D3 (supplement) 125 micrograms (mcg); expired August 2022; In the stock supply medication bin: -four boxes major brand loperamide hydrochloride tabs 2 mg, labeled for R2 with the name crossed off: two unopened boxes, one opened box with 12 of 24 tablets remaining, and one opened box with three of 24 tablets remaining, all expired September 2022; -Bayer aspirin (for pain) 325mg, two bottles, expired August 2022, and October 2012; -Aspercreme lidocaine (for pain) patches, seven patches expired as of December 2022; -Zyrtec (for allergies) 10 mg tablets, expired December 2022; and -acetaminophen (for pain) 500 mg tablets, expired October 2022. The stock supply medication bin also included the following medications bearing labels for residents identified by RN-F as discharged or deceased residents: -Dr. Sheffields brand cortisone (anti-itch) cream, expired October 2021; -senexon (constipation) 8.6 mg tablet, expiring March 2025; and -vitamin B1 (supplement) 100 mg tablets, expiring January 2024.	01910		

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01910	Continued From page 21 On February 21, at 3:08 p.m., RN-F stated the licensed practical nurse (LPN) performing medication set-up should identify expired medications. On February 21, at 3:14 p.m., director of nursing (DON)-B stated LPNs would be expected to go through the medications to identify expired medications. DON-B further stated she also reviewed medication storage monthly. DON-B further stated the house stock was used to administer to residents if their medications were not refilled in time, and medications bearing the label of another resident were likely put in the stock medication bin by mistake. The licensee's Medication Management Services policy, revised March 11, 2022, indicated, "The RN will develop and update as needed specific procedures for the following medication management activities:" including, "controlling and storing medications including controlled substances", and "disposal of unused medications, including controlled substances". No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility	01940		

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01940	Continued From page 22 must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure it developed an individual treatment management plan to include all required content for two of three residents (R13, R3, R2) who received an ordered treatment 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	01940		

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01940	Continued From page 23 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: R13 R13's diagnosis included type 2 diabetes. R13's service plan dated December 23, 2022, indicated the resident received management of prescribed treatment services. R13's prescriber orders dated February 8, 2023, included blood glucose checks three times a day fasting and before meals. R13 lacked a treatment management plan to include required content noted below: -documentation of specific resident instructions relating to the treatment or therapy administration: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services: and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R3 R3's diagnoses included type 2 diabetes. R3's service plan dated September 5, 2022, indicated R3 received services including assistance with blood glucose (BG) management. R3's prescriber orders dated February 1, 2023, indicated BG checks three times daily.	01940		

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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
01940	Continued From page 24 R3 lacked a treatment management plan to include required content noted below: -documentation of specific resident instructions relating to the treatment or therapy administration: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services: and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. R2 R2's diagnoses included type 2 diabetes. R2's service plan dated February 7, 2023, indicated R2 received services including assistance with blood glucose management. R2 lacked a treatment management plan to include required content noted below: -documentation of specific resident instructions relating to the treatment or therapy administration: -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services: and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On February 21, 2023, at 4:30 p.m., R13 was	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20712	A. BUILDING: _____ B. WING _____	02/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HOMESTEAD AT MAPLEWOOD	1890 SHERREN AVENUE EAST MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 25 observed eating in the dining room. ULP-G stated R13 needed BG checks, but R13 was always eating dinner upon her arrival for her shifts and she was unable to do BG checks until after dinner. On February 22, 2023, at 1:03 p.m., director of nursing (DON)-B stated the medication administration record (MAR) did not include BG testing instructions or indication when the unlicensed personnel (ULP) should contact the nurse regarding BG levels for R3. DON-B stated she had a posting on the wall on the 3rd floor that indicated when to contact the nurse, including BG parameters. On February 22, 2023, at 2:30 p.m., DON-B indicated she was aware there were no parameters for the blood sugar checks and they were being done after dinner. DON-B stated the blood sugar checks were only being done because R13 had requested they be done. The licensee's Development of the Treatment and Therapy Services and Individualized Treatment and Therapy Record policy, dated August 1, 2021, indicated the treatment or therapy management plan would include: a. A statement of the services that will be provided; b. Documentation of specific resident instructions relating to treatments or therapy administration; c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel; d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatment or therapy services; and e. Any resident - specific requirements related to documentation or treatment and therapy	01940		

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	20712	A. BUILDING: _____ B. WING _____	02/27/2023

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01940	Continued From page 26 received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications and adverse reactions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for two of four residents (R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).	01960		

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	20712	A. BUILDING: _____ B. WING _____	02/27/2023

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01960	Continued From page 27 Findings include: R3 R3's diagnoses included type 2 diabetes. R3's service plan dated September 5, 2022, indicated R3 received services including assistance with blood glucose (BG) management. R3's prescriber orders dated February 1, 2023, directed to obtain BG checks three times daily. On February 21, 2023, at 4:00 p.m., surveyor observed unlicensed personnel (ULP)-G, perform blood glucose testing for R4 according to provider orders. R3's medication administration record (MAR, which was also used for blood glucose treatment documentation) for February 2023, lacked documentation of blood glucose checks, or why the checks were not performed, on the following scheduled dates and times: - February 11 at 6:00 and 11:00 a.m.; - February 13-15, at 6:00 a.m. R4 R4's diagnoses included Alzheimer's disease, chronic kidney disease, and type two diabetes mellitus. R4's service plan dated November 10, 2022, indicated R4 received services including assistance with blood glucose monitoring and medication administration. R4's service plan indicated blood glucose levels to be tested three times per day. R4's record lacked a physician order for blood glucose testing. A signed order indicating blood glucose levels to be tested three times daily was obtained by registered nurse (RN)-B, dated	01960		

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01960	Continued From page 28 February 22, 2023, during the survey. R4's MAR, (which was also used for blood glucose treatment documentation) for February 1-22, 2023, lacked documentation of blood glucose checks, or why the checks were not performed, on the following scheduled dates and times: - February 11, at 8:00 a.m., 12:00 p.m., and 4:30 p.m.; and - February 17, at 12:00 p.m. On February 22, 2023, at 12:32 p.m., director of nursing (DON)-B stated the BG documentation was part of the insulin administration within the MAR. DON-B further stated they would look to see if the missing BG testing results might be documented somewhere else. On February 23, 2023, at 5:15 p.m., DON-B stated (via email) the BG test results were not found elsewhere in the record. The licensee's Development of the Treatment and Therapy Services and Individualized Treatment and Therapy Record policy, dated August 1, 2021, indicated, "Administration of treatments or therapies will be documented in the residents in PCC [point click care]. Documentation will included electronic signature and title, date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up, if needed." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960		

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02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment or hazard vulnerability assessment of the physical environment on and around the property with mitigation factors for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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). Findings include: On February 23, 2023, at approximately 12:30 p.m., records were provided for review. Records were reviewed by survey staff on February 23,	02040		

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02040	Continued From page 30 2023, between 12:30 p.m. and 1:15 p.m. Record review of the available documentation indicated that the licensee had included a Hazard and Vulnerability Assessment Tool within the Emergency Preparedness Manual but had not performed a safety risk assessment or hazard vulnerability assessment on and around the property for the physical environment with mitigation factors. On February 23, 2023, at approximately 1:30 p.m., the licensed assisted living director (LALD)-A verified this deficient condition. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for five of eight residents (R3, R7, R10, R11, R12) who utilized hospital bed rails or consumer grab bars. This resulted in issuance of an immediate correction order on February 21, 2023.	02310		

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02310	Continued From page 31 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at 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: R3 R3 had diagnoses to include type 2 diabetes, edema, and chronic kidney disease. R3's service plan dated December 30, 2022, indicated services including dressing, toileting, transfers, activities of daily living (ADLs), medication management and treatment management. On February 21, 2023, at 1:23 p.m., a U-shaped consumer grab bar was observed to be affixed on the right side, by insertion beneath the mattress of R3's bed, and positioned at the head of the bed. On February 21, 2023, at 1:45 p.m., R3 stated he had used the consumer grab bar for 20 years, and brought it when he was admitted to the facility. R3's record lacked documentation of assessment, documentation of the risk versus (vs) benefits discussion of consumer grab bar use with R3, documentation the consumer grab bar was checked for recalls and was installed, used, and maintained according to manufacturer's guidelines.	02310		

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02310	Continued From page 32 R7 R7 had diagnoses to include atrial fibrillation. R7's service plan dated August 12, 2022, included services of safety checks. On February 21, 2023, at 3:45 p.m., an observation of R7's assistive device located on her bed included bilateral consumer grab bars which were secured to the upper aspect of the bed. R7's record lacked documentation the consumer grab bars were checked for recalls and were installed, used, and maintained according to manufacturer's guidelines. R10 R10 had diagnoses to include dementia. R10's service plan dated September 9, 2022, included services of medication management. On February 21, 2023, at 3:30 p.m., an observation of R10's hospital bed included two upper bed rails with one in the down position on the right, and the left in the up position. R10's Uniform Nursing Assessment dated December 6, 2022, lacked measurements of R10's hospital bed rails. R10's record lacked documentation of measurements of the hospital bed rails and documentation of the risk vs benefits discussion of bed rail use with R10 or their responsible party. R11 R11 had diagnoses to include obsessive compulsive disorder. R11's service plan dated October 4, 2022, included services of bathing and medication management.	02310		

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02310	Continued From page 33 On February 21, 2023, at 3:45 p.m., an observation of R11's hospital bed included bilateral bed rails affixed to the upper aspects of the bed and in the down position. R11's assessments dated November 17, 2022, and February 14, 2023, lacked documentation of a R11's hosptial bed rails. R11's record lacked an assessment, including measurements for hospital bed rail use, documentation of the risk vs benefits discussion of hospital bed rails used with R11 or their responsible party. R12 R12 had diagnoses to include Alzheimer's disease. R12's service plan dated July 29, 2022, included services of bathing, toileting, and medication management. On February 21, 2023, at 3:55 p.m., an observation of R12's hospital bed included bilateral upper hospital bed rails with the right side in the up position and the left in the down position. R12's assessment dated January 16, 2023, indicated "siderails do not appear to be indicated." R12's record lacked documentation of the risk vs benefits discussion of hospital bed rail use with R12 or their responsible party, and measurements of R12's side rails. On February 21, 2023, at approximately 3:30 p.m., director of nursing (DON)-B stated the hospital side rails were not measured and both	02310		

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02310	Continued From page 34 the hospital bed rails and consumer grab bars had not been assessed for safety. DON-B further verified lack of documented evidence education was provided to the resident/resident representative on the risks associated with hospital bed rail and consumer grab bar use. The Food and Drug Administration (FDA) "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information provided. TIME PERIOD FOR CORRECTION: Immediate An immediate correction order was identified on February 21, 2023, at 6:43 p.m., and issued for tag identification 2310. On February 22, 2023, at 3:45 p.m., the immediacy of correction order 2310 was removed, however, non-compliance remained at a scope and level of I.	02310		

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

Type: Full
Date: *02/22/23*
Time: 13:28:25
Report: 1021231036

Food and Beverage Establishment Inspection Report

Location:
The Homestead At Maplewood
1890 Sherren Avenue East
Maplewood, MN55109
Ramsey County, 62

Establishment Info:
ID #: 0039373
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6517703959
ID #:

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

The following orders were issued during this inspection.

4-300 Equipment Numbers and Capacities

4-302.12B ** Priority 2 **

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

ESTABLISHMENT HAS DIAL THERMOMETERS ON-SITE. PROVIDE A DIGITAL THERMOMETER WITH A SMALL DIAMETER PROBE AS DESCRIBED IN RULE ABOVE.

Comply By: 03/01/23

4-600 Cleaning Equipment and Utensils

4-601.11A ** Priority 2 **

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

TOMATO SLICER WAS FOUND STORED WITH OTHER CLEAN EQUIPMENT AND THE SLICER HAS DRIED FOOD DEBRIS ON THE BLADES. DIRECTOR TOOK THE TOMATO SLICER TO THE DISH MACHINE TO CLEAN AND SANTIZE. CORRECTED ON-SITE. CLEAN AND SANITIZE AFTER EACH USE.

Comply By: 02/22/23

4-600 Cleaning Equipment and Utensils

4-601.11C

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

IT LOOKS LIKE THE FRP WALLS NEXT TO THE COLD AND HOT WELLS IN THE KITCHEN WERE ONCE PAINTED OVER AND THE PAINT IS PEELING OFF. THE FRP WALLS ALSO HAVE SPLASHING OF DRIED FOOD DEBRIS. CLEAN FRP WALLS IN THE KITCHEN.

Comply By: 03/01/23

4-900 Protecting Clean Items

4-904.11A

MN Rule 4626.0965A Handle, display, and dispense all single-service and single use articles and clean utensils so that contamination of lip-contact and food-contact surfaces is prevented.

PLASTIC SINGLE USE FORKS, SPOONS, AND KNIVES IN THE KITCHEN AND MEMORY CARE WERE FOUND STORED IN A CUTLERY BIN WITH THE HANDLE SIDE AND THE LIP SIDE INTERTWINED. SEE COMMENTS.

Comply By: 02/22/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

THE LAMINATE CABINETS IN THE MEMORY CARE SERVING KITCHEN ARE PEELING OFF IN SOME AREAS AND THEY ARE NO LONGER SMOOTH AND EASILY CLEANABLE. REPAIR OR REPLACE CABINETS.

Comply By: 03/22/23

Surface and Equipment Sanitizers

Quaternary Ammonia: = 200PPM at Degrees Fahrenheit
Location: SANI BUCKET
Violation Issued: No

Quaternary Ammonia: = 400PPM at Degrees Fahrenheit
Location: THREE COMPARTMENT SINK
Violation Issued: No

Final Utensil Surface Temp: = at 162 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SLICED TOMAT0 - COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: HAWAIIAN TURKEY SALAD - COLD WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT MELON - COLD WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 172 Degrees Fahrenheit - Location: BEEF PATTIES - HOT WELLS
Violation Issued: No

Process/Item: Hot Holding
Temperature: 164 Degrees Fahrenheit - Location: CHICKEN - HOT WELLS
Violation Issued: No

Process/Item: Cold Holding
Temperature: 38 Degrees Fahrenheit - Location: CUT MELON - MEAT WALK-IN COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: PASTEURIZED LIQUID EGGS - MEAT WALK-IN COOLER
Violation Issued: No

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

Process/Item: Cold Holding
Temperature: 41 Degrees Fahrenheit - Location: MILK - TRAULSEN UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 40 Degrees Fahrenheit - Location: SALAD - TRAULSEN UPRIGHT COOLER
Violation Issued: No

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

ALL FINDINGS ON THIS REPORT WERE DISCUSSED WITH DIRECTOR OF FOOD SERVICES, JUSTIN KLUNK AND HEALTH REGULATION DIVISION NURSE EVALUATORS.

PER CONVERSATION WITH JUSTIN, FOOD IS MADE FOR SAME DAY SERVICE. NO LEFTOVERS ARE KEPT.

CONTINUATION OF MN Rule 4626.0965A
DISCUSSED WITH DIRECTOR THE CORRECT METHODS TO STORE AND DISPLAY SINGLE USE CUTLERY TO PREVENT HAND CONTAMINATION OF THE MOUTH PART. STAFF WILL STORE ALL CUTLERY FACING THE SAME DIRECTION SO IT IS EASIER TO PICK UP THE CUTLERY FROM THE HANDLE.

THE KITCHEN IN MEMORY CARE HAS RESIDENTIAL EQUIPMENT, LAMINATE FLOORING, AND POPCORN CEILING. PHYSICAL FACILITY ITEMS WILL BE MONITORED AT FUTURE INSPECTIONS.

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1021231036 of 02/22/23.

Certified Food Protection Manager: JUSTIN W. KLUNK

Certification Number: FM95576 Expires: 09/18/24

Inspection report reviewed with person in charge and emailed.

Signed: _____

JUSTIN KLUNK
DIRECTOR OF FOOD SERVICES

Signed:

Melissa Ramos
Environmental Health Specialist
Metro District Office
651-201-4495
Melissa.Ramos@state.mn.us