



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 10, 2022

Administrator
The Beacon At Mapleton
206 3rd Avenue Northeast
Mapleton, MN 56065

RE: Project Number(s) SL30605015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on July 14, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

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

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

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

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

The total amount you are assessed is \$500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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

Please address your cover letter for general reconsideration requests to:

Free from Maltreatment reconsideration requests should be addressed to:

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

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

REQUESTING A HEARING

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

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

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

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,



Jessie Chenze, RN, BSN
Interim HFE Supervisor 1 | State Evaluations Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Office: 218-332-51751 | Mobile: 651-508-2791 | Fax: 218-332-5196

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER THE BEACON AT MAPLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 206 3RD AVENUE NE MAPLETON, MN 56065		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments Initial comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(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: SL30605015 On July 12, 2022, through July 14, 2022, 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 fourteen (14) residents, all of whom received services under the provider's Assisted Living Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 17 residents in the Assisted Living with Dementia Care facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report,	0 480		

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0 480	Continued From page 2 dated July 12, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to establish and maintain infection control policies and procedures that complied with accepted health care, medical, and nursing standards for infection control related to the COVID-19 pandemic when the licensee failed to ensure visitors, employees, and residents were screened for COVID-19 with temperature checks and screening questions at the entrance to the establishment and failed to develop policies and procedures to guide decision making related to COVID-19 pandemic. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 510		

Minnesota Department of Health

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0 510	Continued From page 3 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 all four residents). The findings include: On July 12, 2022, at 10:00 a.m., the surveyor was greeted at the front door by assisted living director (ALD)-C wearing a face mask covering the nose and mouth. ALD-C was also wearing eye protection. The surveyor was not screened at the front entrance before entering licensee's establishment. ALD-C escorted the surveyor through common area and dining area to a room where other staff members were working. ALD-C then screened the surveyor by obtaining a temperature using a temporal thermometer and having the surveyor read a form and answer screening questions related to COVID-19 symptoms. During interview on July 12, 2022, at approximately 1:15 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated anyone whether employee or visitor would be screened for COVID-19 symptoms at the entrance of the establishment before being allowed to enter the building. The Minnesota Department of Health's COVID-19 PPE and Source Control Grids dated April 7, 2022, indicated all employees who work in a congregated health care setting, including assisted living facilities, are recommended to be screened for COVID-19 symptoms before entering an establishment. The licensee lacked a Standard (Universal)	0 510		

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0 510	Continued From page 4 Precautions for Infection Control policy with identification of when employees, residents, and visitors would be required to wear what personal protection equipment related to COVID-19 and lacked identification of when the licensee would screen and obtain temperature of employees, residents, and staff related to COVID-19. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) Days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to post the required information related to the information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC). This had the potential to affect all the licensee's current residents, staff, and visitors.	0 550		

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0 550	Continued From page 5 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 July 12, 2022, at approximately 11:30 a.m., during a facility-wide tour, the surveyor did not observe a posting in a conspicuous place the required information for reporting suspected maltreatment to MAARC. On July 12, 2022, at approximately 12:05 p.m., licensed assisted living director/ registered nurse (LALD/RN)-A confirmed the required grievance procedure content had not been posted. LALD/RN-A stated the phone number to MAARC is posted on the wall at each of the licensee's phones. The licensee's Vulnerable Adult Reporting-Assisted Living Licensure policy revised August 1, 2021, did not include the new Assisted Living Licensure requirements related to posting information in a conspicuous place. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 6 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee (unlicensed personnel (ULP)-B) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	0 660		

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0 660	Continued From page 7 The findings include: The licensee's TB risk assessment dated January 2022, indicated the licensee was a low risk setting for TB transmission. ULP-B had a hire date of April 10, 2022. ULP-B provided directed care to residents of the assisted living. ULP-B's employee record lacked a completed two-step TST. ULP-B's employee record indicated ULP-B had started the two step TST series. The first TST administration was conducted on April 11, 2022. There was no signature indicating who had given ULP-B the TST test. The results of that test were read on April 13, 2022, by a registered nurse (RN). ULP-B's record lacked documentation that a second TST was completed. During an interview on July 12, 2022, at 11:30 a.m., licensed assisted living director/registered nurse (LALD/RN)-A stated she was not aware ULP-B did not have evidence of a completed two step TST test. The Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, noted baseline screening for all health care workers (HCW) included a history and symptom screen, and testing for the presence of TB infection. The licensee's Staff Screening Policy dated January 2020, indicated staff whose essential job functions require work within the same air space of home care clients would be screened and tested for tuberculosis prior to the staff being exposed to clients.	0 660		

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0 660	Continued From page 8 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record	0 680		

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0 680	Continued From page 9 review, the licensee failed to post an emergency preparedness plan prominently. This had the potential to impact all residents, staff, and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 12, 2022, at approximately 11:25 a.m., during a tour of the facility, the surveyor did not observe any signage or information regarding the licensee's emergency disaster or preparedness plan posted in a prominent location. On July 12, 2022, at approximately 12:10 p.m., the surveyor requested the licensee's emergency disaster or preparedness plan. Licensed assisted living director/registered nurse (LALD/RN)-A provided a red binder consisting of all documents related to the licensee's emergency management plan. During interview on July 12, 2022, at approximately 2:15 p.m., LALD/RN-A stated she was not aware the licensee had not posted the emergency preparedness information. LALD/RN-A stated emergency evacuation floor plans were posted on the back of every resident room but indicated these diagrams were not posted in the common areas. LALD/RN-A also stated the emergency procedures were posted in the area where staff congregate and was aware	0 680			

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0 680	Continued From page 10 this information was not visible to residents or visitors to review. The licensee's Plans for Natural Disasters and Emergencies policy dated June 1, 2020, indicated the licensee would have a written plan of action to facilitate our client's care and services in response to a natural disaster or any type of emergency that may affect our ability to provide services. This plan will be updated regularly and will be coordinated with local emergency responders, and where appropriate, with the management of senior housing buildings or HWS establishments where our clients reside. The policy did not indicate that it would post the licensee plan for staff, resident, or visitors to review. No additional information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure resident records were protected	0 700			

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0 700	Continued From page 11 against unauthorized disclosure of electronic records. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 12, 2022, at 11:39 a.m., the surveyor observed a laptop computer sitting on top of the medication cart in an area where medications are dispensed by staff. Unlicensed personnel (ULP)-B was in the process of dispensing medications for R3 and using the laptop on the medication cart to verify medications for a resident. After ULP-B finished with dispensing the medications, ULP-B proceeded to lock the medication cart and walked out of medication room leaving R3's electronic medication administration record open on the laptop. On July 14, 2022, at 1:10 p.m., directly following the above observation, licensed assisted living director/registered nurse (LALD/RN)-A confirmed residents' private medical information should not have been left unattended and visible on the computer screen. Assisted living director (ALD)-C commented "she [ULP-B] is nervous." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER THE BEACON AT MAPLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 206 3RD AVENUE NE MAPLETON, MN 56065		
(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
0 780	Continued From page 12	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 maintain smoke alarms in the facility and ensure smoke alarms are interconnected so that actuation of one alarm causes all alarms in the dwelling to actuate as required. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER THE BEACON AT MAPLETON		STREET ADDRESS, CITY, STATE, ZIP CODE 206 3RD AVENUE NE MAPLETON, MN 56065		
(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
0 780	Continued From page 13 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: On 07/13/2022 between 11:30 AM to 12:30 PM, survey staff observed that smoke alarms located in bedrooms were not interconnected to smoke alarms located in the immediate vicinity of the sleeping area. (RN/LALD)-A verbally confirmed survey staff observations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER THE BEACON AT MAPLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 206 3RD AVENUE NE MAPLETON, MN 56065		
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0 800	Continued From page 14 failed to maintain the facility physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). Findings include: On 07/13/2022 between 11:30 AM to 12:30 PM, survey staff observed at a point of egress that the concrete sidewalk had separated from its original attachment to the door threshold and had sunk, resulting in a 4 inch vertical displacement. It was also observed that the same concrete egress pathway was not level, exhibiting a horizontally sloping along its length, sinking towards the foundation of the building resulting in a non-level walkway (RN/LALD)-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/14/2022
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0 810	Continued From page 15 plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to conduct the required evacuation drills twice per year per shift with at least one evacuation drill every other month, and document the drills and staff participation. This has the potential to directly affect all residents, staff, and visitors.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2022
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0 810	Continued From page 16 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 the potential to affect a large portion or all residents). Findings include: On 07/13/2022 between 11:30 AM to 12:30 PM, survey staff review of documentation revealed that no records were provided to confirm that evacuation drills are being conducted twice per year per shift with at least one drill every other month (RN/LALD)-A verbally confirmed survey staff observations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01490 SS=F	144G.63 Subd. 4 Training required relating to dementia All direct care staff and supervisors providing direct services must demonstrate an understanding of the training specified in section 144G.64. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure staff received dementia training in the required areas for three of three	01490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2022
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01490	Continued From page 17 employees (licensed assisted living director/registered nurse (LALD/RN)-A, unlicensed personnel (ULP)-B, assisted living director (ALD)-C) with employee records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee transitioned from a comprehensive home care to an assisted living with dementia care on August 1, 2021. LALD/RN-A started employment with licensee on October 3, 2016. ULP-B started employment with licensee on April 10, 2022. ALD-C started employment with licensee on June 6, 2019. LALD/RN-A, ULP-B and ALD-C's employee files lacked evidence of completing dementia care training in the topics; - an explanation of Alzheimer's disease and other dementias; - assistance with activities of daily living; - problem solving with challenging behaviors; - communication skills; and - person-centered planning and service delivery.	01490		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2022
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01490	Continued From page 18 On July 12, 2022, at approximately 11:45 a.m., LALD/RN-A acknowledged the employee files were missing dementia care training and stated all employees are in the process of completing this education. The licensee's undated Training Requirement for Assisted Living with Dementia Care policy indicated supervisors of direct-care staff must have at least eight hours of initial training on topics specified per statute within 120 working hours of the employment start date; direct-care employees must have completed at least eight hours of initial training on topics specified within 160 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01490		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to designate a qualified person to oversee staff training in the care of individuals	02140		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/14/2022
NAME OF PROVIDER OR SUPPLIER THE BEACON AT MAPLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 206 3RD AVENUE NE MAPLETON, MN 56065		
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02140	Continued From page 19 with dementia. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Licensed assisted living director/registered nurse (LALD/RN)-A had a hire date of October 3, 2016, and provided supervision and training to unlicensed personnel (ULP) in the licensee's assisted living with dementia care establishment. Assisted living director (ALD)-C had a hire date of June 6, 2019, and provided supervision to ULPs in the licensee's assisted living with dementia care establishment. During the entrance conference on July 12, 2022, at approximately 10:30 a.m., LALD/RN-A stated she oversaw training staff in the care of individuals with dementia. On July 12, 2022, at approximately 12:00 p.m., LALD/RN-A stated she had not completed an approved competency and knowledge test required for supervising staff in an assisted living facility with dementia care; however, both she and assisted living director (ALD)-C were currently working on the required training in dementia care needed to obtain competency/certification. No further information was provided.	02140			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30605	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/14/2022
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02140	Continued From page 20	02140		
02410 SS=D	TIME PERIOD TO CORRECT: Twenty-One (21) days 144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure services were provided in a person-centered manner that promoted resident choice, dignity and privacy for one of one resident	02410		

Minnesota Department of Health

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02410	Continued From page 21 (R4) reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During observation on July 12, 2022, at approximately 11:48 a.m., R4 was seated in a reclining wheelchair covered in a blanket with eyes closed in the common area of the licensee's establishment. The surveyor and several other residents were seated in the vicinity of the R4. ULP-D approached R4 and stated to resident, "we need to go to your room and check your underwear." R4 did not respond to ULP-D and ULP-D proceeded to push R4 in the reclining wheelchair toward hallway of the establishment. During an interview on July 12, 2022, at approximately 2:40 p.m., licensed assisted living director/registered nurse (LALD/RN)-A stated that the licensee takes dignity and privacy of the residents very serious and acknowledged that ULP-D spoke inappropriately to R4. LALD/RN-A stated that ULP-D would need to be re-educated in resident dignity. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		



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

Type: Full
Date: 07/12/22
Time: 14:00:25
Report: 1020221076

Food and Beverage Establishment Inspection Report

Page 1

Location:

Beacon at Mapleton
206 3rd Avenue NE
Mapleton, MN56065
Blue Earth County, 07

Establishment Info:

ID #: 0007869
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

The Beacon at Mapleton

Phone #: 5075244990
ID #: 46612

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.

THIN FOODS SERVED AT THE ESTABLISHMENT.

Comply By: 07/31/22

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

NO CFPM.

Comply By: 01/31/23

Surface and Equipment Sanitizers

Wash Temperature Gauge: = at 150 Degrees Fahrenheit

Location: DISHWASHER

Violation Issued: No

Final Rinse Temperature Ga: = at 190 Degrees Fahrenheit

Location: DISHWASHER

Violation Issued: No

Final Rinse Temperature Ga: = at 172 Degrees Fahrenheit

Location: DISHWASHER

Violation Issued: No

Food and Equipment Temperatures

Type: Full
Date: 07/12/22
Time: 14:00:25
Report: 1020221076
Beacon at Mapleton

Food and Beverage Establishment Inspection Report

Page 2

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: SALSBURY STEAK - UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: MAC N CHEESE - UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER
Violation Issued: No

Process/Item: Cold Holding
Temperature: <0 Degrees Fahrenheit - Location: FOODS FIRM - UPRIGHT FREEZER
Violation Issued: No

Process/Item: Cooking
Temperature: 157 Degrees Fahrenheit - Location: MASHED POTATOES - STOVE TOP
Violation Issued: No

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

GENERAL COMMENTS:

DISCUSSED EMPLOYEE ILLNESS POLICY AND PROCEDURE. AN EMPLOYEE ILLNESS LOG IS USED ON-SITE. AN ILLNESS REPORTING FACT SHEET PROVIDED WITH THE REPORT.

DISCUSSED COOLING AND REHEATING PROCEDURES. A COOLING LOG WAS PROVIDED WITH THE REPORT.

A FACT SHEET ON MN CERTIFIED FOOD PROTECTION MANAGER WAS PROVIDED WITH THE REPORT.

DISCUSSED DOCUMENTED WASH TEMPERATURE, RINSE TEMPERATURE, AND UTENSIL SURFACE TEMPERATURE FOR THE DISHWASHER ON THE TEMPERATURE LOGS USED AT THE ESTABLISHMENT. A THERMOMETER CALIBRATION LOG WAS ALSO PROVIDED WITH THE REPORT.

Type: Full
Date: 07/12/22
Time: 14:00:25
Report: 1020221076
Beacon at Mapleton

Food and Beverage Establishment Inspection Report

Page 3

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 1020221076 of 07/12/22.

Certified Food Protection Manager: _____

Certification Number: _____ Expires: ____ / ____ / ____

Inspection report reviewed with person in charge and emailed.

Signed: Report emailed
Establishment Representative

Signed: Ashley B
Ashley B

651-201-4500

Report #: 1020221076

Food Establishment Inspection Report



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

No. of RF/PHI Categories Out

1

Date 07/12/22

No. of Repeat RF/PHI Categories Out

0

Time In 14:00:25

Legal Authority MN Rules Chapter 4626

Time Out

Beacon at Mapleton

Address

206 3rd Avenue NE

City/State

Mapleton, MN

Zip Code

56065

Telephone

5075244990

License/Permit #

0007869

Permit Holder

The Beacon at Mapleton

Purpose of Inspection

Full

Est Type

Risk Category

M

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	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	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	Food received at proper temperature		
13	IN	OUT		Food in good condition, safe, & unadulterated		
14	IN	OUT	N/A	Required records available; shellstock tags, parasite destruction		

Protection from Contamination

15	IN	OUT	N/A	Food separated and protected		
16	IN	OUT	N/A	Food contact surfaces: cleaned & sanitized		
17	IN	OUT		Proper disposition of returned, previously served, reconditioned, & unsafe food		

Compliance Status

COS R

Time/Temperature Control for Safety

18	IN	OUT	N/A	Proper cooking time & temperature		
19	IN	OUT	N/A	Proper reheating procedures for hot holding		
20	IN	OUT	N/A	Proper cooling time & temperature		
21	IN	OUT	N/A	Proper hot holding temperatures		
22	IN	OUT	N/A	Proper cold holding temperatures		
23	IN	OUT	N/A	Proper date marking & disposition		
24	IN	OUT	N/A	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		
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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.

GOOD RETAIL PRACTICES

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

Mark "X" in box if numbered item is **not** in compliance

Mark "X" in appropriate box for COS and/or R

COS= corrected on-site during inspection

R= repeat violation

Safe Food and Water

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	Plant food properly cooked for hot holding		
35	IN	OUT	N/A	Approved thawing methods used		
36	X			Thermometers provided & accurate		

Food Identification

37				Food properly labeled; original container		
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Prevention of Food Contamination

38				Insects, rodents, & animals not present		
39				Contamination prevented during food prep, storage & display		
40				Personal cleanliness		
41				Wiping cloths: properly used & stored		
42				Washing fruits & vegetables		

Proper Use of Utensils

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) *Report emailed*

Date: 07/13/22

Inspector (Signature)

Mya R