



Protecting, Maintaining and Improving the Health of All Minnesotans

March 29, 2023

Licensee
Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN 56636

RE: Project Number(s) SL33975015

Dear Licensee:

On March 7, 2023, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the December 21, 2022, evaluation were corrected. This follow-up evaluation verified that the facility is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Jessica Chenze'.

Jessica Chenze, Supervisor
State Evaluation Team
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 Fax: 651-281-9796

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 10, 2023

Licensee
Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN 56636

RE: Project Number(s) SL33975015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on December 21, 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.

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 - 0340 - 144g.30 Subd. 5 - Correction Orders - \$3,000.00

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

St - 0 - 2070 - 144g.81 Subd. 4 - Awake Staff Requirement - \$3,000.00

The total amount you are assessed is \$9,000.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up 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:

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

Free from Maltreatment reconsideration requests should 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

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,



Jessica Chenze, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: jessica.chenze@state.mn.us
Telephone: 218-332-5175 | Fax: 218-332-5196

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2022
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(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: SL#33975015 On December 19, 2022, through December 21, 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 23 active residents; all of whom were receiving services under the Assisted Living with Dementia Care license. As of December 21, 2022, at time of exit, the immediacy of correction orders 1290 and 2070 remained, and non-compliance remains at a scope and level of I for both correction orders.	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.	
0 250 SS=F	144G.20 Subdivision 1 Conditions (a) The commissioner may refuse to grant a	0 250		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 250	Continued From page 1 provisional license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the owner, controlling individual, or employee of an assisted living facility: (1) is in violation of, or during the term of the license has violated, any of the requirements in this chapter or adopted rules; (2) permits, aids, or abets the commission of any illegal act in the provision of assisted living services; (3) performs any act detrimental to the health, safety, and welfare of a resident; (4) obtains the license by fraud or misrepresentation; (5) knowingly makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter; (6) denies representatives of the department access to any part of the facility's books, records, files, or employees; (7) interferes with or impedes a representative of the department in contacting the facility's residents; (8) interferes with or impedes ombudsman access according to section 256.9742, subdivision 4; (9) interferes with or impedes a representative of the department in the enforcement of this chapter or fails to fully cooperate with an inspection, survey, or investigation by the department; (10) destroys or makes unavailable any records or other evidence relating to the assisted living facility's compliance with this chapter; (11) refuses to initiate a background study under section 144.057 or 245A.04; (12) fails to timely pay any fines assessed by the	0 250		

Minnesota Department of Health

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0 250	Continued From page 2 commissioner; (13) violates any local, city, or township ordinance relating to housing or assisted living services; (14) has repeated incidents of personnel performing services beyond their competency level; or (15) has operated beyond the scope of the assisted living facility's license category. (b) A violation by a contractor providing the assisted living services of the facility is a violation by the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they met the requirements of licensure, by attesting the managerial officials who oversaw the day-to-day operations understood applicable statutes and rules; nor developed and/or implemented current policies and procedures as required with records reviewed. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 19, 2022, at 12:55 p.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A stated the licensee's employees in charge of the	0 250		

Minnesota Department of Health

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0 250	Continued From page 3 facility were familiar with the assisted living regulations and the licensee provided medication and treatment management services. The licensee's Application for Assisted Living License, section titled Official Verification of Owner or Authorized Agent owner (O)-K, identified, I certify I have read and understand the following: [a check mark was placed before each of the following]: - I have read and fully understand Minn. [Minnesota] Stat. [statute] sect. [section] 144G.45, my building(s) must comply with subdivisions 1-3 of the section, as applicable section Laws 2020, 7th Spec. [special] Sess [session]., chpt. [chapter] 1. art. [article] 6, sect. 17. - I have read and fully understand Minn. Stat. sect. 144G.80, 144G.81. and Laws 2020, 7th Spec. Sess., chpt. 1, art. 6, sect. 22, my building(s) must comply with these sections if applicable. - Assisted Living Licensure statutes in Minn. Stat. chpt. 144G. - Assisted Living Licensure rules in Minnesota Rules, chpt. 4659. - Reporting of Maltreatment of Vulnerable Adults. - Electronic Monitoring in Certain Facilities. - I understand pursuant to Minn. Stat. sect. 13.04 Rights of Subjects of Data, the Commissioner will use information provided in this application, which may include an in-person or telephone conference, to determine if the applicant meets	0 250		

Minnesota Department of Health

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0 250	Continued From page 4 requirements for assisted living licensing. I understand I am not legally required to supply the requested information; however, failure to provide information or the submission of false or misleading information may delay the processing of my application or may be grounds for denying a license. I understand that information submitted to the commissioner in this application may, in some circumstances, be disclosed to the appropriate state, federal or local agency and law enforcement office to enhance investigative or enforcement efforts or further a public health protective process. Types of offices include Adult Protective Services, offices of the ombudsmen, health-licensing boards, Department of Human Services, county or city attorneys' offices, police, local or county public health offices. - I understand in accordance with Minn. Stat. sect. 144.051 Data Relating to Licensed and Registered Persons (opens in a new window), all data submitted on this application shall be classified as public information upon issuance of a provisional license or license. All data submitted are considered private until MDH issues a license. - I declare that, as the owner or authorized agent, I attest that I have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659 governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. - I have examined this application and all attachments and checked the above boxes indicating my review and understanding of	0 250		

Minnesota Department of Health

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0 250	Continued From page 5 Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct, and complete. I will notify MDH, in writing, of any changes to this information as required. - I attest to have all required policies and procedures of Minn. Stat. chapter 144G and Minn. Rules chapter 4659 in place upon licensure and to keep them current as applicable. Page six was electronically signed by authorizing agent O-K on May 27, 2022. The licensee had an assisted living license reissued on August 1, 2022, with an expiration date of June 30, 2023. The licensee failed to ensure the following policies and procedures were developed and/or implemented: - conducting and handling background studies of employees, - requirements in section 626.557, reporting of maltreatment of vulnerable adults; - infection control practices, - medication management, and - treatment and therapy management As a result of this survey, the following orders were issued 0250, 0340, 0470, 0480, 0510, 0640, 0680, 0780, 0790, 0800, 0810, 0820, 0910, 1290, 1640, 1760, 1770, 1890, 1900, 1910, 1940, 2040, 2070, 2310, 2320, indicating the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.08 to 144G.95. No further information was provided.	0 250		

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0 250	Continued From page 6	0 250			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
0 340 SS=I	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, or an employee of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or e-mail copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the immediate orders, tag identification 1290 and 2070, during a survey completed on December 21, 2022.	0 340			

Minnesota Department of Health

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0 340	Continued From page 7 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: On December 21, 2022, the Minnesota Department of Health (MDH) completed a survey resulting in 24 correction orders issued which included immediate orders 1290 and 2070 issued on December 20, 2022. On December 20, 2022, at 1:44 p.m., licensed assisted living director (LALD)-B was notified via email by MDH of immediate correction orders for tags 1290 and 2070. On December 20, 2022, at 7:47 p.m., LALD-B responded via email with attachments of the two corrections for the 2 tags and "to let them know if you need anything further." On December 21, 2022, at 8:47 a.m., LALD-B was notified via email by MDH the information supplied was insufficient to remove the immediacy for both tags 1290 and 2070. On December 21, 2022, at 1:27 p.m., LALD-B responded via e-mail and wrote "Hi- I read the email and will work on the corrections for the immediacies [sic]". On December 21, 2022, at 2:25 p.m., the	0 340		

Minnesota Department of Health

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0 340	Continued From page 8 immediacy of the two immediate orders identified remained as the survey was exited. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

Minnesota Department of Health

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0 470	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the licensee failed to post a staffing plan in the secured memory care unit. This had the potential to affect all 10 residents in the secure unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a client'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 clients). The findings include: The licensee held an assisted living with dementia care license, expiration date June 30, 2023. During a facility tour on December 19, 2022, at 2:45 p.m., with registered nurse (RN)-A, the surveyor observed the licensee lacked a posting of the daily staff work schedule in an area accessible for staff, residents, volunteers, and the public to view in the secured memory care unit. RN-A stated it was posted in the main entrance of the assisted living building, but not in the memory care unit. The licensee's NUR-9.0, Staffing, Direct-Care Staffing Plan & Daily Schedule policy dated August 1, 2021, indicated the daily work schedule will be posted at the beginning of each shift and will be posted in a central location in each building of the facility or campus accessible to staff, residents, volunteers, and the public.	0 470		

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 470	Continued From page 10 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 480		

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0 480	Continued From page 11 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated December 20, 2022, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 510 SS=D	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 ensure infection control standards were followed for one of two unlicensed personnel (ULP)-F during medication administration for R2. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of	0 510		

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0 510	Continued From page 12 residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 20, 2022, at 7:35 a.m., the surveyor observed ULP-F log into the electronic record and start the medication administration process for R2. ULP-F did not complete hand hygiene prior to preparing R2's scheduled oral medication. At 7:38 a.m., the surveyor observed ULP-F administer R2's scheduled morning medications and return to the electronic record and document R2's medications as administered. ULP-F did not perform hand hygiene and proceeded to follow the same medication administration process for another resident. On December 20, 2022, at 7:52 a.m., ULP-F stated she usually washed her hands or used hand sanitizer before and after medication administration. ULP-F stated she did not wash her hands or use hand sanitizer before or after R2's medication administration and did not complete hand hygiene prior to another resident's medication administration. On December 21, 2022, at 10:46 a.m., registered nurse (RN)-A stated staff should perform hand hygiene before and after medication administration and should complete hand hygiene in between residents. The licensee's undated Training Unlicensed [sic] Personnel for Medication, Treatment and Therapy Administration policy, noted infection control techniques that must be followed when administering medications, treatment and therapy including handwashing and the use of gloves	0 510		

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0 510	Continued From page 13 when appropriate. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated May 2, 2022, indicated infection control precautions must be followed when administering medications, treatments, and therapy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required content in common areas to include: posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and posting information and reporting number for the	0 640		

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0 640	Continued From page 14 Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. 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 client'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 clients). The findings include: On December 19, 2022, at 2:45 p.m., during tour and observation, the licensee was noted not to have posted 911 numbers in the commons area, near office phones or in secured memory care unit, nor posted information and reporting number for MAARC. On December 19, 2022, at 3:05 p.m., registered nurse (RN)-A stated the facility did not have the required postings for 911 emergency or the information and reporting number for MAARC, but the 911 emergency number was in the emergency book. Also, she stated the facility used to have a portable phone for residents to use but was unsure what happened to it, and most residents have their own mobile phones. Licensee's Emergency and Disaster Preparedness policy dated August 1, 2022, did not address posting of 911 emergency number or reporting number for MAARC. No further information was provided.	0 640		

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0 640	Continued From page 15	0 640		
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days			
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 review, the licensee failed to have all the written requirements in the emergency preparedness	0 680		

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0 680	Continued From page 16 plan (EPP) and failed to post the plan prominently. In addition, the licensee failed to ensure its missing person policy was updated at least quarterly. This had the potential to affect all 23 residents, staff and any visitors of 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: Upon entrance to the facility on December 19, 2022, at 12:30 p.m., the surveyor observed there was no signage posted or information regarding the licensee's emergency preparedness plan. A request was made to licensed assisted living director (LALD)-B to review the licensee's EPP, which was later provided. EMERGENCY PREPAREDNESS PLAN The licensee's EPP had a collection of a risk analysis tool and policies addressing: fire, fire drills and equipment, bomb threat, heat/humidify, electrical outage and heating, ventilation and air conditioning (HVAC) failure, severe winter weather, chemical exposure, sheltering in place, evacuation and others. The EPP was not tailored for the facility's site. The licensee's EPP lacked the following required content: -correct organizational profile; -correct staff list; -description of the population served by licensee;	0 680		

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0 680	Continued From page 17 -procedure for tracking staff; -development of all policies/procedures, based on assessment; and additional policies for; -procedures for tracing of staff and patients; -transportation arrangements; -arrangements with other facilities; -policies/procedures to address role of facility under a waiver declared by Secretary. -development of a communication plan; -methods for sharing information; -sharing information on occupancy/needs; -method for sharing information/notifications with family; -EP training and testing program; -training program for staff; and -annual EP testing requirements. MISSING RESIDENT PLAN Contained in the licensee's EPP was the licensee's missing resident policy, with no effective date. In addition, there was no documentation the missing resident plan had been reviewed at least quarterly by the LALD-B or registered nurse (RN)-A. On December 19, 2022, at 3:05 p.m., the RN-A stated the EP is kept in our (LALD-B and RN-A office) office. The LALD-B and RN-A office was only assessable by the LALD-B and RN-A via a punch key assess on the door handle. On December 21, 2022, at 11:48 a.m., the surveyor interviewed LALD-B via phone. LALD-B stated, "a consultant completed and updated the EP due to the last inspection at a sister location, including the organizational profile and staff list." On December 21, 2022, at 12:08 p.m., LALD-B stated the organizational profile and staff list were incorrect and was looking to see if she had	0 680		

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0 680	Continued From page 18 corrected information in her office. On December 21, 2022, at 12:29 p.m., LALD-B stated she was looking for additional documents as part of the EPP. Licensee's Document No: 000.00.00 Emergency and Disaster Preparedness policy dated August 1, 2022, indicated the facility will be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning. In addition, the facility would post the EPP prominently. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
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	0 780		

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0 780	Continued From page 19 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 resident sleeping rooms. 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, 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 December 21, 2022, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the owner (O)-K. During the facility tour, survey staff observed that smoke alarms were not installed in resident sleeping rooms. This deficient condition was verified by O-K accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		

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0 790	Continued From page 20	0 790		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide fire extinguishers with no more than 75 feet travel distance in the facility and failed to provide portable fire extinguishers that were readily accessible to all occupants within the facility. This deficient condition had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On December 21, 2022, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the	0 790		

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0 790	Continued From page 21 owner (O)-K. During the facility tour, survey staff observed that there was one portable fire extinguisher in the dementia care unit, which was located in a locked laundry room. The laundry room fire extinguisher was not readily visible and accessible for use, and fire extinguishers were not provided within 75 feet of travel. These deficient conditions were visually verified by O-K accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain 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. 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	0 800		

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0 800	Continued From page 22 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 December 21, 2022, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the owner (O)-K. During the facility tour, survey staff observed the following: 1. There was no documentation available that required annual fire sprinkler system maintenance had been performed. 2. A discharge pipe was not installed for the pressure relief valve on the water heater in the mechanical room. 3. Escutcheons were not installed on several sprinklers, which are necessary to ensure that the fire sprinkler heads will activate properly. 4. A fan was plugged into a power strip in resident room 4. 5. There was no documentation available that the annual well water test had been performed. Documentation was requested by survey staff but not provided. These deficient conditions were verified by O-K accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The	0 810			

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0 810	Continued From page 23 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 record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required elements; failed to provide required employee training on the fire safety and evacuation plans; and failed to complete required employee evacuation drills. This deficient condition had the potential to affect	0 810		

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0 810	Continued From page 24 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 December 21, 2022, at approximately 12:30 p.m., records were provided for review. Records were reviewed by survey staff on December 21, 2022, between 12:30 p.m. and 1:40 p.m. 1. Record review of available documentation indicated that the licensee had not developed and maintained fire safety and evacuation plans for this facility location. a. The emergency evacuation route maps included in the plans were for another facility location. The location and number of resident sleeping rooms were not identified in the written plans provided for review. b. The fire extinguisher and emergency green button locations identified in the plans were not accurate. The plans referenced buildings A, B, and C, which did not match the floor plan of this facility. 2. Record review of the available documentation indicated that the licensee had not developed plans with employee actions on how to move or evacuate residents in the event of a fire or similar emergency from this facility location. 3. Record review of available documentation	0 810		

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NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
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0 810	Continued From page 25 indicated that the licensee did not include fire protection procedures necessary for residents or 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 in the plans from this facility location. 4. Record review of available documentation indicated that the licensee did not provide employee training on the fire safety and evacuation plans upon hire and at least twice per year thereafter. Documentation was requested by survey staff but not provided to support that the required employee training frequency had been met. 5. Record review of evacuation drills indicated that evacuation drills for employees had been conducted in July, August, October, and December of 2022. The time or shift was not recorded for the July drill. The other drills were performed during PM hours. The evacuation drill frequency requirement of twice per year per shift with at least one evacuation drill every other month was not met. On December 21, 2022, at approximately 1:45 p.m., the registered nurse (RN)-A confirmed the findings during an interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=F	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as	0 820		

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0 820	Continued From page 26 housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to directly affect all residents and staff. 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 December 21, 2022, between 10:30 a.m. and 12:30 p.m., survey staff toured the facility with the owner (O)-K. During the facility tour, survey staff observed that the exit doors were locked and required code entry into a keypad to open. O-K explained during the facility tour that the exit doors would open with a loss of power or by pushing one of the green emergency buttons. O-K further explained that two green buttons were installed in the facility, one in the hallway	0 820		

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0 820	Continued From page 27 near the front office and the other at the nurse station in the dementia care unit. Means to automatically open the exit doors in the event of a fire by either activation of the fire alarm or sprinkler system was not provided. This deficient condition was verified by O-K accompanying on the facility tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 820		
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the license number of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for three of three residents (R1, R2, R6). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety), and was issued at a	0 910		

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0 910	Continued From page 28 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: R1's Resident Agreement (assisted living contract) effective October 15, 2021, was signed by the resident October 2, 2022. R2's Resident Agreement effective September 23, 2022, was signed by R2's guardian September 23, 2022. R6's Resident Agreement effective December 14, 2021, was signed by the resident December 14, 2021. R1, R2, and R6's assisted living contracts lacked the following required content: - the correct HFID number (provider identification number); and - the correct physical mailing address of the facility and contracted service provider when applicable On December 21, 2022, at 10:44 a.m., registered nurse (RN)-A stated the contract was the current contract used by the licensee for all residents. RN-A stated the license number and address information listed on the contract was incorrect as it was for the licensee's other assisted living facility in a nearby town. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910		

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01290	Continued From page 29	01290		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current employee records contained all the required content to include a background study clearance letter for six of seventeen employees, (kitchen staff (K)-J, licensed practical nurse (LPN)-C, unlicensed personnel (ULP)-E, ULP-G, ULP-H, ULP-I.) 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).	01290		

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01290	Continued From page 30 The findings include: This resulted in an immediate correction order on December 20, 2022, at approximately 1:35 p.m. K-J K-J was hired April 30, 2018, to provide dietary needs to the facility's residents. On December 20, 2022, at 11:40 a.m., licensed assisted living director (LALD)-B verbalized K-J was employed as a kitchen staff member. LALD-B provided K-J's schedule at 12:37 p.m. from November 20, 2022 through December 17, 2022, K-J worked 16 shifts out of 28 days. K-J's record lacked documentation of a cleared background study. On December 20, 2022, at 11:23 a.m., the surveyor verified via Net Study 2.0, K-J's background study was listed as ineligible LPN-C LPN-C was hired February 23, 2022, to provide direct care services to the facility's residents. On December 20, 2022, at 11:41 a.m., LALD-B stated LPN-C is a current staff member providing services to residents. LPN-C's record lacked documentation of a background study affiliated with the facility's licensee. ULP-E ULP-E was hired June 20, 2010, to provide direct care services to the facility's residents. On December 20, 2022, at 8:42 a.m., the	01290		

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01290	Continued From page 31 surveyor observed ULP-E exit R3's room. ULP-E stated she was getting supplies to do R3's wound care. ULP-E stated she works at both of the licensee's facilities, and she provides direct care including medication administration (R3 declined to have the surveyor observe his wound care treatment). On December 20, 2022, at 11:41 a.m., LALD-B stated ULP-E is a current staff member providing services to residents. ULP-E's record lacked documentation of a cleared background study affiliated with the facility's licensee. ULP-G ULP-G was hired on July 25, 2017, to provide direct care services to the facility's residents. On December 20, 2022, at 6:28 a.m., the surveyor observed ULP-G working on the assisted living floor. On December 20, 2022, at 11:41 a.m., LALD-B stated ULP-G is a current staff member providing services to residents. ULP-G's record lacked documentation of a cleared background study affiliated with the facility's license. ULP-H ULP-H was hired January 17, 2019, to provide direct care services to the facility's residents. On December 20, 2022, at 9:07 a.m., the surveyor observed ULP-H providing breakfast to residents.	01290		

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01290	Continued From page 32 On December 20, 2022, at 11:41 a.m., LALD-B stated ULP-H is a current staff member providing services to residents ULP-H's record lacked documentation of a cleared background study affiliated with the facility's licensee. ULP-I ULP-I was hired October 9, 2018, to provide direct care services to the facility's residents. On December 20, 2022, at 9:07 a.m., the surveyor observed ULP-I providing breakfast to residents. On December 20, 2022, at 11:41 a.m., LALD-B stated ULP-I is a current staff member providing services to residents ULP-I's record lacked documentation of a cleared background study affiliated with the facility's licensee. The licensee's policy and procedure for BACKGROUND CHECKS (sic) reads All employees; as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS (Department of Human Services). Only those with satisfactory results will continue to work with the facility and its residents. No further information provided. TIME PERIOD FOR CORRECION: Immediate As of survey exit on December 21, 2022, at 2:25 p.m., the immediacy of this order had not been removed.	01290		

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01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans were updated for two of three residents (R2, R6). 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	01640		

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01640	Continued From page 34 of the residents). The findings include: R2 R2's service plan dated September 26, 2022, indicated unlicensed personnel (ULP) were providing wound care every three days. R2's provider orders dated October 5, 2022, included an order to increase wound care to once daily, apply betadine (medication used to promote healing in skin wounds) and keep covered. R2's service plan lacked evidence indicating revision of treatments to match current orders. On December 21, 2022, at 12:58 p.m., licensed assisted living director (LALD)-B stated R2's service plan had not been updated to reflect the more frequent wound care treatments. R6 R6's service plan dated December 14, 2021, indicated ULP were providing wound care every three days, however, the service plan did not reflect current wound care frequency as ordered for R6. R6's assessment dated September 21, 2022, indicated skin issues as dry and ashy and specified resident has a dry area to her belly button/scalp she likes to pick at and occasionally it will start to bleed. Staff to utilize gentamicin cream as ordered. Staff to apply Tegaderm or Mepilex to the belly button area to cover it to help prevent picking at the areas. If it is noticed she is picking, alert nursing staff if dressing is applied. R6's electronic medication administration record	01640		

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01640	Continued From page 35 (EMAR), dated December 2022, indicated the following medications: -triamcinolone 0.1 % cream, apply 1 gram three times a daily, Apply a thin film sparingly to two lesions on scalp and skin surrounding belly button (seborrich dermatitis); and -gentamicin 0.1% ointment daily to affected area(s) once daily. R6's prescriber orders dated December 7, 2022, included: -triamcinolone 0.1 % cream, apply 1 gram three times a daily (seborrich dermatitis), Apply a thin film sparingly to two lesions on scalp and skin surrounding belly button; -gentamicin 0.1% Ointment daily to affected area(s) once daily and; -per signed standing order, dated December 7, 2022: steri-strips and/or antibiotic ointment or bacitracin to skin tears/lesions, cover with a dry dressing or Mepilex boarder gauze per nurse instruction until healed. On December 20, 2022, at 4:22 p.m., registered nurse (RN)-A stated R6 no longer has wounds, and the service plans were not updated, "I didn't know each time something changed I needed to do that. I need to sit down and go through them all." The licensee's Contents of Service Plans policy dated May 2, 2022, indicated service plans would be reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-on (21) days	01640		

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01760	Continued From page 36	01760		
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 according to manufacturer's instructions for one of three residents (R6). 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: R6's diagnoses included diabetes mellitus, acute chronic heart failure, and acute kidney injury.	01760		

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01760	Continued From page 37 R6's service plan and individualized management plan dated December 14, 2021, included medication management services. R6's assessment dated September 27, 2022, indicated unlicensed personnel (ULP) will administer all medications ordered by the provider and the nurse will update staff of any special medication instructions per medication as needed. R6's electronic medication administration record (EMAR) for December 2022 indicated R6 would receive: sevelamer carb 800 milligrams (mg) tabs, take 3 tabs (2400 mg) by mouth three times a day with meals, and sevelamer carb 800 mg, take 1 tab a day with snack (phosphate inhibitor). R6's prescriber orders dated December 7, 2022, matched the orders on the EMAR for R6. On December 20, 2022, at 8:30 a.m., the surveyor observed ULP-F prepare R6's oral medications (including sevelamer) and insulin and verify the medications in the EMAR. While ULP-F was preparing the sevelamer carb 3 tabs, the surveyor observed ULP-F break the sevelamer carb 3 tabs in half (with gloved hands). ULP-F stated we do this per the resident's request because they are so big and hard for her to swallow, the nurses know about it. On December 22, 2022, at 10:42 a.m., registered nurse (RN)-A stated no medications should be broken in half, unless on EMAR and directed by the nurses, and asked if it was R6's sevelamer, ULP should be putting this medication in applesauce or yogurt.	01760		

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01760	Continued From page 38 Per Davis Drug Guide for Nurses, 2019 edition, sevelamer carbonate film coated tablets should be taken whole. Do not crush, chew or split tablet. The licensee's Medication, Treatment and Therapy Reminders policy dated May 2, 2022, noted a RN will conduct a nursing assessment of a resident's functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services and develop an individualized treatment and therapy plan for the resident based on the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for two of two residents (R1, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01770		

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01770	Continued From page 39 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: During the entrance conference on December 19, 2022, at 1:10 p.m., registered nurse (RN)-A stated the licensee provided medication management services. R1 R1's diagnoses included depression, paranoia, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), anxiety, hypertension (HTN-high blood pressure), and history of polio. R1's service plan dated February 28, 2022, indicated R1 received medication management services. R1's Assessment dated November 14, 2022, indicated R1 needed full medication management and setup services. R1's prescriber orders dated December 7, 2022, included orders for lorazepam (antianxiety medication) 1 milligram (mg) daily; Methenamine Hippurate (used to treat chronic urinary tract infections) 1 gram (gm) twice daily; potassium chloride (mineral supplement) 10 mEq (one-thousandth of an equivalent) three times daily; acetaminophen extra strength 1000 mg three times daily; aspirin (heart health) 81 mg daily; vitamin D 2000 units two tablets daily; vitamin C 500 mg twice daily; prenatal multivitamin plus iron daily; and Zoloft (antidepressant) 200 mg three times daily.	01770		

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01770	Continued From page 40 R6 R6's diagnoses included CHF, HTN, dementia, acute metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently), end state renal (kidney) disease, diabetes, and depression. R6's service plan dated December 14, 2021, indicated R6 received medication management services. R6's Assessment dated January 3, 2022, indicated R6 needed full medication management and setup services. R6's prescriber orders dated December 7, 2022, included orders for Imodium (medication to treat loose stools) 2 mg as needed; Aldactone (diuretic) 25 mg daily; hydralazine (antihypertensive) 50 mg four times daily; and levetiracetam (anticonvulsant) 750 mg twice daily. R1 and R6's records lacked documentation for medication setup at the time of setup to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, route of administration and name of person completing medication setup. On December 19, 2022, at 2:07 p.m., the surveyor toured the facility with registered nurse (RN)-A, including a review of the locked medication room and assisted living medication cart. At 2:20 p.m. the surveyor observed in the medication cart 28 day preset blister packs (a transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to package tablets) of the above noted medications for R1 and R6. Most of the blister packs had a hand -written label which included the name of the medication, dosage, and resident's name.	01770		

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01770	Continued From page 41 On December 19, 2022, at 2:30 p.m., RN-A stated the medications in the blister packs noted above for R1 and R6 had been setup by licensed practical nurse (LPN)-C. RN-A stated they "don't document medication setup - didn't know it was required." The licensee's Documentation of Medication, Treatment and Therapy Management Services dated May 2, 2022, noted the RN will document the services the resident will receive on the resident's individualized medication management plan and individualized treatment and therapy plan and resident's medication/treatment record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for five of five residents (R4, R5, R6, R7, R8).	01890		

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01890	Continued From page 42 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 December 19, 2022, at 2:07 p.m., the surveyor toured the facility with registered nurse (RN)-A, including a review of the locked medication room and medication carts on the assisted living and memory care units. RN-A observed and confirmed the following: R4 R4's opened Novolog 100 units/milliliter (ml) and Lantus 100 units/ml insulin pens (a multiple dose pen shaped injector device for insulin administration) did not have a label which indicated the date the pens had been opened and when the pens would expire. R5 R5's Spiriva Respimat 2.5 microgram (mcg) inhaler (bronchodilator) lacked an original prescription label with information regarding the directions for use, resident's name, the pharmacy in which it had been issued, and the date the inhaler had been removed from the package. R6 R6's blister pack (a transparent, molded piece of plastic, often sealed to a sheet of cardboard, used to package tablets) of Imodium 2 milligrams (mg) lacked an original prescription label with	01890		

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01890	Continued From page 43 information regarding directions for use, resident's name, and the pharmacy in which it had been issued. R7 R7 had two bottles of warfarin tablets (blood thinner). On the side of the first bottle R7's first name and initial of last name along with warfarin 3 mg was written with a black marking pen [the bottle contained ten whole tablets and one tablet cut in half]. On the side of the second bottle R7's first name and initial of last name along with warfarin 2.5 mg was written with a black marking pen [the bottle contained five 2.5 mg tablets and one 3 mg tablet]. R7's bottles of warfarin lacked an original prescription label with information on directions for use, medication dosage, resident's full name, and the pharmacy in which it had been issued. R8 R8's Lidocaine 5% transdermal patch (pain relieving patch) lacked an original prescription label with information regarding the directions for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. On December 19, 2022, at 2:40 p.m., RN-A stated all medication should be labeled appropriately and insulin pens and inhalers should be dated with a date when opened. RN-A stated she had a guide in the cupboard that the staff could refer to if they couldn't remember. The manufacturer's instructions for Lantus insulin pens dated December 2019, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it.	01890		

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01890	Continued From page 44 The manufacturer's instructions for Novolog, dated June 2021, directed to discard the pen 28 days after it had been opened, even if it still had insulin left in it. The manufacturer's instructions for Spiriva Respimat inhaler, dated July 2020, directed to discard the inhaler three months after it had been removed from the package. The licensee's Storage of Medications policy dated May 2, 2022, noted a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medication. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01900 SS=E	144G.71 Subd. 21 Prohibitions No prescription drug supply for one resident may be used or saved for use by anyone other than the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the prescription drug supply for two of two residents (R9, unknown resident) were not saved for use by anyone other than the resident for which the	01900		

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01900	Continued From page 45 medication was prescribed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 19, 2022, at 2:48 p.m., the surveyor toured the facility with registered nurse (RN)-A, including a review of the locked stock medication cupboard in the medication room. The following were observed amongst the stock medication in the stock medication bin: - one opened bottle of acetaminophen extra strength 500 milligrams (mg) with a prescription label intact and directions to take 1-2 tabs every six hours. The resident name on the prescription bottle was blackened out with a marker, however, RN-A stated she could read the name and the medication was prescribed for R9 who had been discharged [R9's discharge records indicated R9 had been discharged on April 21, 2022] - one opened bottle of acetaminophen 500 mg with a pharmacy label which was mostly removed from the bottle On December 19, 2022, at 2:52 p.m., RN-A stated the medication bottles noted above had been prescribed for specific residents and the labels on the bottles had been partially removed or altered and someone placed them in the stock medication bin. RN-A stated these medications had the potential to be administered to another	01900		

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01900	Continued From page 46 resident. RN-A stated, "I didn't know the bottles were in there - [the medications] should have been disposed of". The licensee's Disposition or Disposal of Medication policy dated May 2, 2022, indicated a resident's current medications that are secured or stored by our facility will be given to the resident or the resident's representative when the resident's medication management services are terminated. Disposal of unused or discontinued prescription drugs managed by the facility may be treated as household waste and may be destroyed by flushing into the sewer system and destroying the labels from the containers. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01900		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by 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	01910		

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01910	Continued From page 47 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, interview and record review, the licensee failed to ensure controlled substances were disposed of according to the facility's policy. This had the potential to affect all residents at 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 the residents). The findings include: During the entrance conference on December 19, 2022, at 1:16 p.m., registered nurse (RN)-A stated the licensee provided medication management services and some of the residents had controlled substances prescribed. RN-A stated when needed all controlled substances were disposed of in a hazardous waste container located in the nursing office. The disposition of these medications was recorded in the resident's electronic record. On December 19, 2022, at 3:58 p.m., the surveyor entered the nursing office with RN-A. The surveyor observed on the top of a shelf above a desk area a red hazardous container	01910		

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01910	Continued From page 48 with a clear lid (a disposal container that is made of rigid semi-clear plastic with a puncture resistant lid on the top). The opening on the top of the lid was not tight fitting and the surveyor observed the container to be over $\frac{3}{4}$ full and the contents of the container included a variety of tablets, patches, and glass injectable containers. RN-A stated all medications including controlled substances were disposed of in this hazardous waste container. RN-A stated when the container is full, they will just toss the container in the household garbage. RN-A stated she has been using this same container to dispose of medications for over a year and it's looking "pretty full". The licensee's Disposition or Disposal of Medication policy dated May 2, 2022, indicated discontinued controlled medications that are managed by the facility would be disposed of by flushing or making non palatable per facility policy. Unused portions of a controlled substance following the termination of a resident's services will be disposed of by flushing the medication by a RN or licensed practical nurse (LPN) with a second person as a witness. The disposal of the controlled substance must be documented in the resident's electronic medical record or on an agency approved form. On December 21, 2022, at 10:37 a.m., RN-A reviewed the facility's policy noted above and stated they were not following their policy regarding disposition of controlled substances. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		

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01940	Continued From page 49	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy management For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a 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 develop and implement a treatment or therapy management	01940		

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01940	Continued From page 50 plan to include all required content for one of three residents (R1) who had treatments managed by 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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 19, 2022, at 1:18 p.m., registered nurse (RN)-A stated the licensee provided treatment and therapy services to residents as prescribed. R1's diagnoses included depression, paranoia, congested heart failure (CHF-condition in which the heart's function as a pump is inadequate to meet the body's needs), anxiety, hypertension (HTN-high blood pressure), and history of polio. R1's prescriber orders dated December 7, 2022, included an order for oxygen therapy 3 liters as needed for shortness of breath or oxygen saturations below 90%. On December 20, 2022, at 7:55 a.m., the surveyor observed in R1's room an oxygen concentrator and a tall oxygen cylinder in the upright position propped up and leaning against the wall and a table. R1's service plan dated February 28, 2022, lacked a written statement of the treatment	01940		

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01940	Continued From page 51 services the resident received to include oxygen therapy. R1's record did not include evidence of an individualized treatment or therapy management plan which included oxygen therapy and identification of treatment or therapy tasks that would be delegated to unlicensed personnel (ULP). On December 21, 2022, at 10:37 a.m., RN-A stated R1's oxygen therapy was not identified on R1's service plan. RN-A stated she had noticed R1's treatment plan for oxygen therapy was incomplete. RN-A stated the ULP would assist R1 with her oxygen. The licensee's Medication, Treatment and Therapy Reminders policy dated May 2, 2022, noted a RN will conduct a nursing assessment of a resident's functional status and need for medication, treatment and therapy reminders or other medication, treatment and therapy management services and develop an individualized treatment and therapy plan for the resident based on the resident's needs and preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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	02040		

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02040	Continued From page 52 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 hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 December 21, 2022, at approximately 12:30 p.m., records were provided for review. Records were reviewed by survey staff on December 21, 2022, between 12:30 p.m. and 1:40 p.m. A Maple Woods hazard vulnerability assessment was provided which referenced a lake across the road. The assessment for this facility location was requested by survey staff but not provided. On December 21, 2022, at approximately 1:45 p.m., the registered nurse (RN)-A confirmed during an interview that the licensee had not	02040		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33975	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2022
NAME OF PROVIDER OR SUPPLIER MAPLE WOODS ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 33310 STATE HIGHWAY 6 DEER RIVER, MN 56636		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02040	Continued From page 53 completed a hazard vulnerability or safety risk assessment on and around the property for this facility location. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02070 SS=I	144G.81 Subd. 4 Awake staff requirement An assisted living facility with dementia care providing services in a secured dementia care unit must have an awake person who is physically present in the secured dementia care unit 24 hours per day, seven days per week, who is responsible for responding to the requests of residents for assistance with health and safety needs, and who meets the requirements of section 144G.41, subdivision 1, clause (12). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one or more persons were physically present and available 24 hours a day, seven days a week, who were responsible for responding to requests for assistance with health and safety needs of residents in one of one secure dementia care units. This had the potential to affect all residents residing in the memory care unit. 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	02070		

Minnesota Department of Health

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02070	Continued From page 54 are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). This practice resulted in an immediate order on December 20, 2022, at approximately 1:35 p.m. The findings include: The licensee held an Assisted Living with Dementia Care license with a bed capacity of 32 residents and had a current census of 23 residents (ten residents residing in the memory care unit and 13 residents residing in the assisted living unit.) During the entrance conference on December 19, 2022, at 1:25 p.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A stated the facility's routine staffing schedule included two unlicensed personnel (ULP) on the day shift (7:00 a.m. to 3:00 p.m.); two ULP on the evening shift (3:00 p.m. to 11:00 p.m.); and two awake ULP on the night shift (11:00 p.m. to 7:00 a.m.). RN-A stated at times the licensee only has one ULP on the night shift due to staffing issues. RN-A stated her scheduled work hours were typically Monday through Friday 8:00 a.m. to 4:00 p.m. At 1:05 p.m., LALD-B stated they have a locked memory care unit which requires a key-pad access code to enter and exit. At 1:07 p.m., RN-A and LALD-B stated they have a couple of residents who required a two-person transfer and a couple of residents who use a mechanical lift (a mechanical device used to assist with transferring.) The physical layout of the facility included a memory care unit which required a key-pad access code to enter and exit. The kitchen area	02070		

Minnesota Department of Health

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02070	Continued From page 55 had two locked doors one which opened into the memory care unit and the second door opened into the assisted living dining room area. These kitchen doors had the potential to be half doors with the capability for the top half to be opened. A review of the facility's staff schedules from September 1, 2022, thru December 20, 2022, noted out of 111-night shifts; 52 of these night shifts had only one staff member scheduled to work. On December 20, 2022, at 6:28 a.m., the surveyor's observed the door to the memory care unit to be wide open. Both kitchen doors were also observed to be open. On December 20, 2022, at 6:32 a.m., ULP-G stated she works fulltime on the night shift. ULP-G stated they [facility staff] leave the memory care unit open all night so they can go back and forth and help residents on both sides. ULP-G stated some residents require two staff to assist with transferring and cares. ULP-G stated the memory care unit could be left unattended for up to 15 minutes if she is busy helping a resident on the assisted living side. ULP-G stated the kitchen door should be shut, but she was waiting for the food truck to come in. On December 20, 2022, from 6:28 a.m. to 7:00 a.m., the surveyor observed the memory care unit door to remain open. On December 20, 2022, at 6:58 a.m., ULP-F stated she works days and used to work primarily evenings. ULP-F stated she does work in the memory care unit. ULP-F stated she only leaves the memory care unit unattended to help a staff member on the assisted living side. ULP-F stated	02070		

Minnesota Department of Health

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02070	Continued From page 56 when she leaves the memory care unit, she makes sure all the residents are safe and in their beds. On December 20, 2022, from 7:14 a.m. to 7:19 a.m., the surveyor observed the memory unit to be unattended with no staff member present. On December 20, 2022, from 7:21 a.m. to 7:52 a.m., the surveyor observed the key-pad access panel for the main entrance door to the facility to have a green light (which indicted the exit door could be opened without entering the key-pad access code). The surveyor was able to open the main entrance door without using the key-pad exit code. On December 20, 2022, at 8:10 a.m., the surveyor observed ULP-D to enter the memory care unit with R11's scheduled medications. At this time the surveyor and ULP-D entered the memory care unit, no other staff members were observed in the unit. At 8:20 a.m., ULP-D stated when she entered the unit at 8:10 a.m. to administer R11's scheduled medications no other staff members were in the memory care unit. On December 20, 2022, at 8:27 a.m., the surveyor entered the memory care unit, no staff were observed to be in the memory care unit. On December 20, 2022, at 8:50 a.m., the surveyor was present in the memory care unit, no staff were observed to be in the memory care unit. The surveyor observed ULP-D returning at 8:53 a.m. and leaving the unit at 8:54 a.m. On December 20, 2022, at 8:54 a.m., the surveyor was present in the memory care unit, no staff were observed to be in the memory care	02070		

Minnesota Department of Health

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02070	Continued From page 57 unit. The surveyor observed ULP-D returning at 8:59 a.m. On December 20, 2022, at 9:57 a.m., RN-A defined the facility's secure unit as a unit that has key-pad access to enter and exit to keep the resident's safe. LALD-B stated they keep the memory care unit doors locked all the time except at night. At 10:03 a.m., LALD-B and RN-A stated the main entrance door key-pad access could be bypassed which left the building unsecure. RN-A stated ULP-G must have taken the garbage out this morning and bypassed the access code leaving the main entrance door unsecure. On December 20, 2022, at 10:15 a.m., LALD-B and RN-A stated some of the night shifts which only had one staff member originally scheduled were covered either by herself or staff working longer shifts, however, there are times when only one staff member worked the night shift. The licensee's Uniform Disclosure of Assisted Living Services and Amenities (UDALSA) dated January 1, 2022, indicated the number of direct care staff typically scheduled for the night shift was two. The facility was a secure unit or building for wandering or exit-seeking behavior. In addition, ULP were in the building and available to respond to resident requests 24/7. The licensee's Direct-Care Staffing Plan dated July 13, 2022, indicated the clinical nurse supervisor developed and was accountable to implement the staffing plan. The building was a secure building. When residents required a two-person assist there would be a minimum of two staff available at all times (currently the facility had one resident which required a two person assist to transfer. The resident who	02070		

Minnesota Department of Health

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02070	Continued From page 58 requires two staff to assist with transferring only gets out of bed if ill and then is transported by EMS). In the event adequate staff is not available/1 staff is on, staff are to call 911 for assistance with transfer. There will be 24-hour awake staff available to respond to resident requests for assistance with health and safety. There will be at least one person staffed on the assisted living unit and one staff assigned to memory care at all times. In the event of inadequate night staff, doors to the memory care unit will be opened to create one continuous unit. The building always remains secured. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate As of survey exit on December 21, 2022, at 2:25 p.m., the immediacy of this order had not been removed.	02070		
02310 SS=D	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 ensure the care and services were provided according to acceptable health care and medical, or nursing standards with regards to safely storing oxygen.	02310		

Minnesota Department of Health

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02310	Continued From page 59 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On December 20, 2022, at 7:55 a.m., the surveyor observed in R1's room a tall oxygen cylinder in the upright position propped up and leaning against the wall and a table. This oxygen cylinder was not stored securely in a holder. On December 20, 2022, at 9:12 a.m., registered nurse (RN)-A stated all oxygen cylinders should be stored in a stand. The surveyor entered R1's room with RN-A. RN-A stated, "I don't know why that (oxygen cylinder) is sitting like that - it should be in a holder." The licensee's undated Oxygen Therapy policy noted oxygen cylinders must be placed in a cart or base to avoid dropping or bumping the tank. The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), noted a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by chains to prevent them from falling over. No further information was provided.	02310		

Minnesota Department of Health

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02310	Continued From page 60	02310		
02320 SS=D	TIME PERIOD FOR CORRECTION: Seven (7) days 144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. 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 medication setup by unlicensed personnel (ULP) for one of one resident (R11). 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: R11's diagnoses included chronic obstructive pulmonary disease (COPD-chronic obstruction of lung airflow that interferes with normal breathing),	02320		

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02320	Continued From page 61 diabetes, and cognitive impairment. R11's service plan dated December 13, 2021, indicated R11 received medication management services to include medication administration four times daily by the ULP. R11's prescriber orders dated May 4, 2022, and December 14, 2022, included orders for aspirin EC (enteric coated - delayed release) 81milligrams (mg) daily, Certavite one tablet (vitamin) daily, escitalopram 5 mg (antidepressant) daily, risperidone 0.5 mg (antipsychotic) twice daily, and Cephalexin 500 mg (antibiotic) one tablet daily for eight days [started December 15, 2022]. On December 20, 2022, at 8:08 a.m., the surveyor observed ULP-F hand ULP-D a medication cup with crushed medications. ULP-F stated the medications were R11's morning medications. The surveyor observed ULP-D to take the medication cup containing R11's crushed medications and enter the kitchen area. ULP-D put a couple spoonsful of yogurt into the medications and mixed them up. At 8:10 a.m., ULP-D proceeded to take the medication cup of crushed pills to R11 who was seated at the dining room table in the memory care unit. The surveyor observed ULP-D administer the medications to R11. On December 20, 2022, at 8:19 a.m., immediately following the above noted observation, ULP-D went to the electronic record to sign off the following medications had been administered aspirin EC 81 mg, Certavite one tablet, escitalopram 5mg, risperidone 0.5 mg, and Cephalexin 500 mg. ULP-D stated ULP-F had put these medications in the medication cup for	02320		

Minnesota Department of Health

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02320	Continued From page 62 R11 and then given them to her to give to R11. ULP-D stated it was not normal for one staff member to set the medications up and for another staff member to administer the medications. On December 21, 2022, at 10:35 a.m., registered nurse (RN)-A stated it was not acceptable practice to have a ULP setup medications for another ULP to administer. The licensee's Administration of Medication, Treatment and Therapy by ULP policy dated May 2, 2022, noted ULP that will provide assistance with medication administration will be trained and competent to follow the following procedure: complete procedures for checking the resident's medication administration record (MAR), follow infection control precautions, prepare medications, administer the medications, and document after administration. According to the American Nurses Association (ANA) effective April 29, 2019, the licensed nurse cannot delegate nursing judgement or any activity that will involve nursing judgement or critical decision making. MN Statute 144G.08, Subd. 41. Medication setup. "Medication setup" means arranging medications by a nurse, pharmacy, or authorized prescriber for later administration by the resident or by facility staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

Type: Full
Date: 12/20/22
Time: 10:12:44
Report: 1019221157

Food and Beverage Establishment Inspection Report

Page 1

Location:

Maple Woods Assisted Living
33310 State Highway 6
Deer River, MN56636
Itasca County, 31

Establishment Info:

ID #: 0038568
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 2189999072
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

4-302.14 ** Priority 2 **

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

OBSERVED FACILITY DID NOT HAVE TEST KITS FOR EITHER THE CHLORINE DISH MACHINE OR FOR THE QUAT. AMMONIA SANITIZER IN THE SPRAY BOTTLES.

Comply By: 12/30/22

5-200C Plumbing: Maintenance, fixture location

5-205.11AB ** Priority 2 **

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

OBSERVED MULTIPLE WET WIPING CLOTHES BEING STORED IN THE BASIN OF THE HAND SINK.

Corrected on Site

7-100 Toxic Labeling

7-102.11 ** Priority 2 **

MN Rule 4626.1595 Clearly label all working containers used for storing poisonous or toxic materials from bulk supplies such as sanitizers and cleaners, with the common name of the product.

OBSERVED SPRAY BOTTLE OF QUAT. AMMONIA THAT WAS NOT LABELED.

Comply By: 12/30/22

Type: Full
Date: 12/20/22
Time: 10:12:44
Report: 1019221157
Maple Woods Assisted Living

Food and Beverage Establishment Inspection Report

Page 2

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

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

OBSERVED MULTIPLE WET WIPING CLOTHS BEING STORED OUTSIDE OF AN APPROVED SANITIZING SOLUTION.

Comply By: 12/30/22

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.

OBSERVED ICE MACHINE ON COUNTER BY COFFEE POTS HAS ACCUMULATIONS OF DEBRIS AROUND THE POUR SPOUT.

Comply By: 12/30/22

Surface and Equipment Sanitizers

Chlorine: = 50 PPM at Degrees Fahrenheit

Location: DISH MACHINE

Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit

Location: SPRAY BOTTLE

Violation Issued: No

Quaternary Ammonia: = 200 PPM at Degrees Fahrenheit

Location: SINGLE USE WIPING CLOTH CONTAINER

Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cold Holding

Temperature: 40 F Degrees Fahrenheit - Location: 3 DOOR FRIDGE

Violation Issued: No

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

INSPECTED FOOD SERVICE OPERATION IN CONJUNCTION WITH HRD INSPECTION.
LEAD HRD INVESTIGATOR WAS JANA BROMENSHENKEL.

Type: Full
Date: 12/20/22
Time: 10:12:44
Report: 1019221157
Maple Woods Assisted Living

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 inspection report number 1019221157 of 12/20/22.

Certified Food Protection Manager: CARLA R. HODGSON

Certification Number: FM 83342 Expires: 04/19/25

Inspection report reviewed with person in charge and emailed.

Signed: _____

CARLA HODGSON
CFPM

Signed: _____

Jared Morrill
Sanitarian
Bemidji
218 308-2128