Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

July 25, 2024

Licensee
Golden Maple Homes Inc
21338 Dodd Boulevard
Lakeville, MN 55044

RE: Initial License Number 411654
Health Facility Identification Number (HFID) 39804
Project Number(s) SL39804015

Dear Licensee:

On July 2, 2024, The Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed July 2, 2024. The follow-up survey found the facility to be in compliance. Based on these findings, the condition(s) on the license were removed effective 07/25/2024.

The Department of Health concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

This is your **official notice** that you have been **granted your assisted living facility license.** Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

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

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

JMD

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF PROVISIONAL EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

April 24, 2024

Licensee
Golden Maple Homes Inc
21338 Dodd Boulevard
Lakeville, MN 55044

RE: Provisional Conditional License Number 411654
Health Facility Identification Number (HFID) 39804
Project Number(s) SL39804015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 19, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.16, Subd. 3(b)(2), MDH is extending the provisional license for 90-days and applying conditions necessary to bring the facility into substantial compliance. The provisional license extension and conditions are due to expire **July 23, 2024**.

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state 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 may be 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.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose 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. MDH 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(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.

MDH may assess fines based on the level and scope of the orders outlined below. The total amount of **potential** fines that may be assessed related to these correction orders is $6,000.00. **MDH is not imposing these fines against your provisional license at this time.**

St - 0 - 0470 - 144g.41 Subdivision 1 - Minimum Requirements - $3,000.00
St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment- $3,000.00

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the provisional licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted for approval. **If corrections are not made, MDH may impose fines as described above and in accordance with Minnesota Statutes 144G.**

The correction order documentation should include the following:

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

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

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

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

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

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

CONDITIONAL LICENSE ISSUED:
MDH will issue Golden Maple Homes Inc a conditional provisional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if Golden Maple Homes Inc is in substantial compliance.

The following conditions apply on the conditional provisional assisted living facility license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional provisional license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the provisional license.

b. **Egress window requirements:** Golden Maple Homes Inc will replace at least one window in the occupied resident sleeping room on the lower level of the facility meeting the minimum size requirements. At least one window in each resident sleeping room must meet the minimum window opening size of no less than 20 inches in width, with a total of at least 648 square inches (4.5 square feet) required for egress, and have a windowsill height from the floor to the clear opening area of 648 square inches, and have a minimum of 20

inches in height and a minimum dimension of 20 inches in width and have a windowsill height from the floor to the clear opening of not more than 48 inches.

c. **No new admissions:** Golden Maple Homes Inc will not admit any new residents under its conditional provisional assisted living facility license until MDH removes the "no new admissions" condition. Golden Maple Homes Inc must provide the Department:

    i. A list of the names and birthdates of any individuals Golden Maple Homes Inc is currently in the process of admitting. These individuals will be able to continue the admittance process.

    ii. A list of all current residents by location including:
        1. Name and birthdate of each resident
        2. Physical location of each resident
        3. Current payment source for services
        4. If Elderly Waiver, the name and contact information of the care coordinator/case manager
        5. If the resident is not able to make informed decisions, the name of their representative and how to contact the representative

d. **Consultant:** Golden Maple Homes Inc will contract with an RN to provide consultation concerning all resident(s) to whom Golden Maple Homes Inc provides provisional licensed assisted living services under the conditional license. <u>The consultant must have access to all resident(s) receiving services from Golden Maple Homes Inc. The consultant will conduct initial and ongoing evaluations of the provider. Direct resident observation may be required based on the consultant's judgement or at the discretion of MDH</u>. The RN must not have any affiliation with Golden Maple Homes Inc and MDH must review the RN's credentials and approve the selection. Golden Maple Homes Inc is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Golden Maple Homes Inc in an effort to help Golden Maple Homes Inc align their practices with the requirements of Minn. Stat. §§ 144G.01 – 144G.9999 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Golden Maple Homes Inc will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

e. **Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Golden Maple Homes Inc and the RN consultant about a change. Each report will be electronically submitted to Jodi Johnson, Surveyor Supervisor, State

Evaluation Team, Health Regulation Division, at jodi.johnson@state.mn.us. Jodi Johnson can be reached at 507-344-2730 (office) with questions about reports. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering assisted living services and the level of competency observed;
iii. Conversations with residents and family members about satisfaction with assisted living services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the assisted living services delivered;
vi. Overall impressions about the dignity with which the residents and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

f. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Golden Maple Homes Inc to correct the violations cited during the survey as well as to determine the overall practice of Golden Maple Homes Inc in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive provisional licensed assisted living services. The OOLTC will share their findings with MDH.

g. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3 or 4 violations or widespread care related violations.

h. **Corrective Action Plan:** Golden Maple Homes Inc will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL PROVISIONAL LICENSE PERIOD:

MDH will determine if Golden Maple Homes Inc is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional provisional license period. If MDH determines Golden Maple Homes Inc is in substantial compliance on the follow up survey, MDH will remove the conditions and grant the assisted living facility license to Golden Maple Homes Inc. If MDH determines Golden Maple Homes Inc is not in substantial compliance, MDH may deny the license pursuant to Minn. Stat. § 144G.16, Subd. 3 (b) (2).

REQUEST FOR RECONSIDERATION:

Pursuant to Minn. Stat. §144G.16, Subd. 4, if a provisional licensee whose assisted living facility license has been denied, or extended with conditions, disagrees with the action taken against the provisional license under this section, the provisional licensee may request a reconsideration no later than 15 calendar days after provisional licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

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

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

If you have any questions, please contact Jodi Johnson directly at: 507-344-2730.

Sincerely,

Rick Michals

Rick Michals, J.D.
Interim Assistant Division Director

Minnesota Department of Health
Health Regulation Division

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	39804	A. BUILDING: _____ B. WING _____	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MAPLE HOMES INC	21338 DODD BOULEVARD LAKEVILLE, MN 55044

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL39804015-0 On March 18, 2024, through March 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four residents; all of whom were receiving services under the Provisional Assisted Living license. 0470: The immediacy has been removed on March 18, 2024; however, non-compliance remains at a scope and level of I (level 3/widespread). 0820: The immediacy has been removed on March 19, 2024; however, non-compliance remains at a scope and level of G (level 3/isolated).	0 000	Minnesota Department of Health is documenting the State 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.	

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0 470	Continued From page 1	0 470		
0 470 SS=I	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; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure that one or more awake staff were available in the assisted living, 24 hours per day, seven days per week, to be responsible for responding to the requests of residents for assistance with health or safety needs. This resulted in an immediate correction	0 470		

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0 470	Continued From page 2 order. 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: The licensee held an assisted living license with a current census of four residents. On March 18, 2024, at 10:30 a.m., during the entrance conference and facility tour, registered nurse (RN)-A stated she staffed one unlicensed personal (ULP) from 8:00 a.m. to 8:00 p.m. and then from 8:00 p.m. to 8:00 a.m. RN-A gave the surveyor a tour and upstairs there was an empty room with a bed that had blankets and sheets disheveled and appeared to have been slept in. During the tour of the basement, the surveyor observed a room curtained off the laundry room that contained a cot with a folded blanket. RN-A stated the staff do not sleep while on duty and the cot and bed were used only during bad weather and they must stay. On March 18, 2024, at 2:30 p.m., RN-A stated that ULP-B was working both shifts today as well as 8:00 a.m. the next morning. ULP-B confirmed he was working 24 hours starting at 8:00 a.m. today and sleeps on the living room sofa. RN-A stated that was not allowed and staff cannot sleep while on duty and told ULP-B that if he sleeps while working, he cannot work for the	0 470		

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0 470	Continued From page 3 licensee. ULP-B later stated he does not sleep while working. Surveyor asked RN-A if it was realistic to have an employee work more than 24 hours and not sleep and RN-A started tearing up and stated she did not like her job and it was too hard. No further information provided. TIME PERIOD FOR CORRECTION: Immediate The immediacy was lifted on March 18, 2024, based on supervisor review and surveyor observation; however, the scope and level remains at a level 3/Widespread (I).	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: (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 4 or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 18, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a	0 660		

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0 660	Continued From page 5 tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of one employee unlicensed personnel (ULP-B). This had the potential to affect all residents and staff in 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 18, 2024, at 10:00 a.m. registered nurse (RN)-A stated upon hire the licensee notifies the employee that they need to get a TB test completed and bring back the results and they will be reimbursed for the test. The licensee's TB facility risk assessment dated January 1, 2024, indicated they were a low risk level. ULP-B started working for licensee on December 2, 2023, to provide direct care to the residents. On March 18, 2024, at 11:40 a.m. the surveyor observed ULP-B administering morning medication to R2.	0 660		

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0 660	Continued From page 6 ULP-B's employee record contained a Baseline TB screening Tool for Health Care Workers (HCWs) dated December 1, 2023, indicating a TB screen was completed. The TB blood test and Tuberculin skin testing (TST) section of the document were left blank. Registered nurse (RN)-A provided the surveyor with ULP-B's U.S. Department of State Vaccination Documentation Worksheet indicating diphtheria, tetanus, and measles were completed in 2020 and 2021. ULP-B's record lacked evidence of TB testing via two-step TST or a blood test. On March 19, 2024, at 11:12 a.m. RN-A stated ULP-B's record did not contain TB testing and stated she remembered getting a copy from the employee when he started but could not locate it. The licensee's Tuberculosis Screening policy dated August 1, 2021, indicated: - new staff will have a blood test or a two-step Mantoux conducted with results documented on the Baseline TB screening tool for HCWs. - No staff will be permitted to begin work until a negative IGRA blood test result is received and documented. - Staff TB screening results will be kept in each employee medical file. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680		

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0 680	Continued From page 7 (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an Emergency Preparedness Plan (EPP) containing all the requirements outlined in Appendix Z. 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	0 680		

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	39804	A. BUILDING: _____ B. WING _____	03/19/2024

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0 680	Continued From page 8 or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 18, 2024, at 10:00 a.m. the EPP was requested and reviewed at a later time. The licensee provided a binder labeled Emergency Preparedness Plan dated January 1, 2024, that had identified their top three issues from their hazard vulnerability assessment (HVA). The EPP failed to show evidence of all the required contents to include: - Process for cooperation and collaboration with local, tribal, regional, State and Federal EP. - Subsistence needs for staff and patients - Policy and procedures for sheltering in place for residents, staff, and volunteers. - Roles under a waiver declared by the Secretary On March 19, 2024, at 2:30 p.m. the EPP manual was reviewed with registered nurse (RN)-A on the missing contents. RN-A agreed to make changes to the EPP. No further information was provided. TIME PERIOD TO CORRECT: 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:	0 780		

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0 780	Continued From page 9 (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the failed to provide smoke alarms outside, in the immediate vicinity of sleeping room #1 on the main level. This affected all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	0 780		

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0 780	Continued From page 10 The findings include: On March 18, 2024, at 10:30 a.m., survey staff toured the facility with registered nurse (RN)-A. During the tour, it was observed a smoke alarm was not installed immediately outside of sleeping room #1 on the main level. During the interview on March 18, 2024, at 10:30 a.m., RN-A confirm a smoke alarm was not installed immediately outside of sleeping room #1 on the main level. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 perform the required annual and monthly maintenance on fire extinguishers as required. This had the potential to affect all current	0 790		

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0 790	Continued From page 11 residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2024, at 10:30 a.m., survey staff toured the facility with registered nurse (RN)-A. It was also observed the fire extinguisher did not have a service tag showing it had been inspected annually and lacked records to show the required monthly visual inspections were performed on the portable fire extinguishers. During the interview on March 18, 2024, at 10:30 a.m., RN-A confirmed required maintenance had not been completed and verified the deficient condition. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810		

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0 810	Continued From page 12 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident 's health or safety, but was not likely to	0 810		

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0 810	Continued From page 13 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 19, 2024, at 12:00 p.m., registered nurse (RN)-A provided documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility. The posted evacuation plans did not show the number of resident rooms. During the interview on March 19, 2024, at 12:00 p.m., RN-A verified the facility needed to update the evacuation plan with the number of resident rooms. The FSEP included the following discrepancies: - The FSEP indicated residents should be evacuated to the safest exit or nearest set of smoke compartment doors away from fire and smoke. This facility was a residential home and did not contain any sort of smoke compartments or smoke compartment doors to contain fire and smoke. - The FSEP indicated when the fire alarm is triggered, all fire doors on magnetic holders will automatically close to contain smoke and fire and residents are to remain behind these doors. The facility did not have any doors that are on magnetic door holders or doors that are rated for smoke and fire. The facility also did not have a fire alarm system that supports the use of magnetic door holders. - The FSEP indicated the system was wired	0 810		

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0 810	Continued From page 14 directly to the fire station. The facility did not have a fire alarm system that supported the direct connection to the fire station. The FSEP included standard employee actions to be taken but failed to provide specific procedures for employees to evacuate residents based on the facility's specific layout in the event of a fire or similar emergency. During the interview on March 19, 2024, at 12:00 p.m., RN-A stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced	0 820		

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0 820	Continued From page 15 by: Based on observation and interview, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident(R)-3 in the bedroom on the lower level. 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 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 March 18, 2024, at 10:30 a.m., survey staff toured the facility with the registered nurse (RN)-A. During the facility tour, survey staff observed the following items: It was observed that the occupied resident bedroom on the lower level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 11 inches in height and 29 inches in width, with a total openable area of 319 square inches. The windows did not meet the minimum requirements for opening height and did not meet the minimum requirements for total openable area. It was also observed the windowsill height was 64 inches from the finished floor and exceeded the	0 820		

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0 820	Continued From page 16 maximum sill height requirement from the finished floor. Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. And the bottom of the egress window opening can be no more than 48 inches from the finished floor. Survey staff explained to RN-A that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. On March 18, 2024, at 11:20 p.m., during the interview, RN-A stated that the resident in the room on the lower level had a compliant bedroom on the main level, but he had moved to the lower level bedroom when he moved into the facility because it had a private bath. During the same interview, survey staff explained to RN-A that an immediate correction order was issued for the above finding. RN-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate. The immediacy was lifted on March 19, 2024, based on supervisor review; however, the scope and level remains at a level 3/Isolated (G).	0 820		

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0 950	Continued From page 17	0 950		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensee provided the required notice for the right to a designated representative with the required verbiage on a document separate from the contract for one of	0 950		

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0 950	Continued From page 18 one resident (R2). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: R2's Resident Agreement dated February 2, 2024, contained a section to identify the designated representative. R2's record lacked evidence in writing of providing on a document separate from the contact verbatim notice of "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." On March 19, 2024, at 10:28 a.m. registered nurse (RN)-A stated she was unaware of the designated representative requirements for the exact language. All residents have the same contract template. No further information was provided.	0 950		

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0 950	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries	01370		

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01370	Continued From page 20 between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one unlicensed personnel (ULP-B). 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: ULP-B was hired on December 12, 2023, to provide direct care under the licensee's assisted living license. On March 19, 2024, at 8:32 a.m. ULP-B was observed providing activities of daily living (ADLs) for R2. ULP-B's employee record contained: - Assisted living orientation checklist from Educare (online training company) - 30-day home health care aide direct supervision sheet dated February 2, 2024.	01370		

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01370	Continued From page 21 ULP-B's employee record lacked evidence ULP-B had demonstrated competency for: - appropriate and safe techniques in personal hygiene and grooming. - standby assistance techniques and how to perform them On March 19, 2024, at 11:28 a.m. registered nurse (RN)-B stated not all ULP-B's competencies were completed. The licensee's Competency Training Evaluation policy dated August 1, 2021, indicated that proper prior to the delegation of services they (the licensee) must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse,	01380		

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	39804	A. BUILDING: _____ B. WING _____	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN MAPLE HOMES INC	21338 DODD BOULEVARD LAKEVILLE, MN 55044

(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
01380	Continued From page 22 and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations included all the required training for one of one unlicensed personnel (ULP-B). 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: ULP-B was hired on December 12, 2023, to provide direct care under the licensee's assisted living license. On March 19, 2024, at 8:32 a.m. ULP-B was observed providing activities of daily living (ADLs) for R2. ULP-B's employee record contained: - Assisted living orientation checklist from Educare (online training company) - 30-day home health care aide direct supervision sheet date February 2, 2024.	01380		

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01380	Continued From page 23 ULP-B's employee record lacked evidence ULP-B had demonstrated competency for: - reading and recording temperature, pulse, and respirations of the resident. - safe transfer techniques and ambulation; and - range of motioning and positioning. On March 19, 2024, at 11:28 a.m. registered nurse (RN)-B stated not all ULP-B's competencies were completed. The licensee's Competency Training Evaluation policy dated August 1, 2021, indicated that proper prior to the delegation of services they (the licensee) must make certain the unlicensed personnel is trained in the proper methods to perform the tasks or procedures for each client and are able to demonstrate the ability to competently follow the procedures and perform the tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01380		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision	01620		

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01620	Continued From page 24 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment no more than 14 calendar days after initiation of services for one of one resident (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 18, 2024, at 10:00 a.m. RN-B indicated the RN was responsible for completing all assessment within	01620		

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01620	Continued From page 25 the required time frame. R2 began receiving services on February 2, 2024, under the facility's assisted living license for seizure disorder, traumatic brain injury (TBI), encephalopathy (neurological change in the brain), diabetes, and HIV (human immunodeficiency). R2's Service Plan dated February 2, 2024, indicated he received services to include assistance with activities of daily living (ADLs) and medication administration. R2's record included the following assessments: - February 2, 2024, initial assessment - February 17, 2024, 14-day assessment (15 days after the initial assessment). On March 19, 2024, at 10:28 a.m. RN-B stated she was aware R2's 14-day assessment was late and stated she was aware of the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record	01880		

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01880	Continued From page 26 review the licensee failed to ensure all medications were securely locked in substantially constructed compartments and permitted access only to authorized personnel. In addition, the licensee failed to ensure the medication refrigerators maintained an acceptable temperature to ensure the medications were stored according to manufacturer's recommendations. 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: During the entrance conference on March 18, 2024, at 10:00 a.m. registered nurse (RN)-A stated the licensee provided medication management to all four residents, and medications were securely stored in a locked medication cabinet located in the medication room. On March 18, 2024, at 11:40 a.m. the surveyor observed unlicensed personnel (ULP)-B administering 3 units of Lispro insulin to R2. R2's room contained a small, unlocked refrigerator sitting on a table. Upon review of the refrigerator with ULP-B, the refrigerator was plugged in, but it was not cool inside to the touch. There was no evidence of a thermometer located inside the refrigerator. ULP-B stated they did not have a thermometer and did not check the	01880		

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01880	Continued From page 27 temperature. The refrigerator contained: - an unopened box of Lantus (long-acting insulin) - one box of Humalog (short-acting insulin) containing three pens - one opened Lantus pen - one opened Humalog insulin pen On March 18, 2024, at 2:12 p.m. RN-A and the surveyor reviewed the contents of R2's refrigerator. RN-A stated the refrigerator did not feel cool inside, and further stated she would get a small medication refrigerator and have a lock put on it. Humalog (Lispro) insulin KwikPen instructions for use dated March 2013, identified unopened Lantus pens should be stored in the refrigerator (36-46 degrees F). The manufacturer's instructions for Lantus insulin pens dated August of 2022, indicated always store unopened Lantus pens in the refrigerator and after first use do not refrigerate. The licensee's Medication Storage policy dated August 1, 2021, indicated: Medication will be stored to prevent diversion of medication. Medication will be stored consistent with manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=F	144G.71 Subd. 20 Prescription drugs	01890		

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01890	Continued From page 28 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 time sensitive medications were dated when opened for one of one resident (R2) with insulin. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 began receiving services on February 2, 2024, under the facility's assisted living license for seizure disorder, traumatic brain injury (TBI), encephalopathy (neurological change in the brain), diabetes, and HIV (human immunodeficiency). R2's Service Plan dated February 2, 2024, indicated he received assistance with activities of daily living (ADLs) and medication administration. R2's medication administration record (MAR) for	01890		

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01890	Continued From page 29 March 2024, indicated R2 took insulin lispro 3 units subcutaneously with breakfast, lunch, and dinner. On March 18, 2024, at 11:40 a.m. the surveyor observed unlicensed personnel (ULP)-B administering 3 units of Lispro insulin to R2. ULP-B confirmed the pen did not have a date of when it was opened or when to discard. R2's Lispro insulin pen lacked an open or expiration date. On March 18, 2024, at 11:45 a.m. registered nurse (RN)-B stated she was aware that insulin pens were not labeled and should be. Humalog (Lispro) insulin KwikPen instructions for use dated March 2013, identified the pen must be used within 28 days or be discarded. The licensee's Medication Management-Administration and Setup policy dated August 1, 2021, failed to indicate the process for labeling time sensitive medication when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
02310 SS=F	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.	02310		

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02310	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents with siderails (R1, R2). This practice resulted in a level two violation (a violation that did not harm a client/resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 began receiving services on January 1, 2024, under the facility's assisted living license for seizure disorder, traumatic brain injury (TBI) and hypertension. R1's Service Plan dated January 1, 2024, indicated he received assistance with activities of daily living (ADLs) and medication administration. On March 19, 2024, at 8:32 a.m. the surveyor observed unlicensed personnel (ULP)-B greeting R1 and assisting with bathing and dressing. R1 was lying in a hospital bed with bilateral side rails in the up position at the top of the bed. R1's record included a siderail assessment dated January 1, 2024, indicating the positive and negative aspects of side rail use had been discussed. The document lacked evidence of	02310		

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02310	Continued From page 31 siderail measurements. R2 R2 began receiving services on February 2, 2024, under the facility's assisted living license for seizure disorder, traumatic brain injury (TBI), encephalopathy (neurological change in the brain), diabetes, and HIV (human immunodeficiency). R2's Service Plan dated February 2, 2024, indicated he received assistance with activities of daily living (ADLs) and medication administration. On March 18, 2024, at 11:40 a.m. the surveyor observed ULP-B administering insulin to R2 while in bed. R2 was lying in a hospital bed with bilateral side rails in the up position at the top of the bed. R2's record included a siderail assessment dated February 2, 2024, indicating the positive and negative aspects of side rail use had been discussed. The document lacked evidence of siderail measurements. On March 19, 2024, at 10:07 a.m. registered nurse (RN)-B stated she was familiar with measuring bed zones for hospital beds in the hospital but was unaware of the requirement in assisted living facilities. The March 10, 2006, FDA Side Rail Entrapment Zones and Dimensional Recommendations indicated to reduce the risk of entrapment, zone 1 (space between the rails), should be less than four and three quarters' inches. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included	02310		

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02310	Continued From page 32 the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) Days	02310		
02320 SS=D	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 and interview. The licensee failed to ensure medications were administered according to policy and accepted standards of practice for one of three residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	02320		

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02320	Continued From page 33 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: On March 18, 2024, at 11:40 a.m. the surveyor observed unlicensed personnel (ULP)-B administering insulin to R2. ULP-B failed to check medication labels and compare them to the medication administration record (MAR) prior to administering the medication. R2's March 2024 MAR included: Insulin Lispro injection solution 3 units with meds daily for diabetes (DM). On March 19, 2024, at 2:05 p.m. registered nurse (RN)-A, stated it was the expectation to review the MAR prior to administering medication, but ULP-B knew R2 so well that they did not do that, but ULP-B should have. The licensee's Medication and Treatment - Administration and delegation policy dated August 1, 2021, indicated the RN must instruct the ULP on the following medication administration tasks before delegating the task to them including: - the complete procedure of checking a resident's medication administration record (MAR). - The ULP must demonstrate their ability to competently follow the delegated medication administration. No further information provided.	02320		

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02320	Continued From page 34 TIME PERIOD FOR CORRECTION: Seven (7) days	02320		
03090 SS=F	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On March 18, 2024, at 10:30 a.m. during the entrance tour, the surveyor noted the electronic signage was posted on the bulletin board in the nurse's station and not at the main entrance. Registered nurse (RN)-A stated she was familiar	03090		

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03090	Continued From page 35 with the requirement of the language and the posting, but was unaware it was required at an entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Type: Full
Date: *03/18/24*
Time: 13:00:00
Report: 1043241061

Food and Beverage Establishment Inspection Report

Location:
Golden Maple Homes Inc
21338 Dodd Boulevard
Lakeville, MN55044
Dakota County, 19

Establishment Info:
ID #: 0039178
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9523933690
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.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW SHELL EGGS STORED ABOVE READY-TO-EAT FOODS (VEGETABLES) AND MILK CONTAINERS IN KITCHEN COOLER AND IN EXTRA COOLER. RAW BACON STORED DIRECTLY BESIDE CARROTS IN KITCHEN COOLER. ADVISED STAFF WITH PROPER STORAGE OPTIONS. COMPLY WITH ABOVE RULE.

Comply By: 03/18/24

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

FOODS (MILK, BUTTER, SOUR CREAM, COOKED CORN, ETC) MEASURED ABOVE 41F IN KITCHEN COOLER. REFER TO DATA CHART. ADVISED STAFF TO DISCARD READY-TO-EAT TCS FOODS. COMPLY WITH ABOVE RULE.

Comply By: 03/18/24

4-200 Equipment Design and Construction

4-201.11GMN

MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

TCS FOODS (COOKED CORN, STEW, ETC) IN KITCHEN COOLER DATE MARKED 3/16. STAFF

CONFIRMED DATE. ADVISED STAFF TO DISCARD FOODS AND TO ONLY SERVE FOODS FOR SAME DAY SERVICE. COMPLY WITH ABOVE RULE.

Comply By: 03/18/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

AMBIENT TEMPERATURE OF KITCHEN COOLER MEASURED 46F. ADVISED STAFF TO STORE TCS FOODS (MEAT, EGGS, DAIRY PRODUCTS, ETC) IN EXTRA COOLER UNTIL UNIT IS REPAIRED/SERVICED TO 41F OR BELOW. COMPLY WITH ABOVE RULE.

Comply By: 03/18/24

Surface and Equipment Sanitizers

Hot Water: = at 206 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: POTATO SALAD
Temperature: 47 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: MILK
Temperature: 46 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: BUTTER
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: PICKLES
Temperature: 47 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: COOKED CORN
Temperature: 50 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: SOUR CREAM
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: AMBIENT
Temperature: 47 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: Yes

Process/Item: SALAMI
Temperature: 39 Degrees Fahrenheit - Location: EXTRA COOLER
Violation Issued: No

Type: Full
Date: *03/18/24*
Time: 13:00:00
Report: 1043241061
Golden Maple Homes Inc

Food and Beverage Establishment Inspection Report

Process/Item: HAM
Temperature: 39 Degrees Fahrenheit - Location: EXTRA COOLER
Violation Issued: No

Process/Item: MILK
Temperature: 39 Degrees Fahrenheit - Location: EXTRA COOLER
Violation Issued: No

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

Discussed date marking, illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Inspection was completed with Carol Fillmore. T.Fearon was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

**Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service only, with leftovers discarded.

**This facility has a residential kitchen with residential equipment and wooden cabinetry. The kitchen finishes and surfaces are well maintained. Contact Health Regulation Division for plan review when facility undergoes remodeling.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043241061 of 03/18/24.

Certified Food Protection Manager Carol Fillmore

Certification Number: FM110730 Expires: 03/07/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Carol Fillmore
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us